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Feeling Happy and Healthy, Having Fun and Friends

Children's understanding of well-being:
a qualitative study

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A thesis submitted in partial fulfilment of the
requirements of the Open University
for the degree of Doctor of Clinical Psychology

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ABSTRACT

Introduction:

The importance of promoting health and well-being has been recognised in recent Government reports and interventions. However, health and mental health have largely been conceptualised as an *absence* of illness and distress, rather than a *presence* of positive health or wellness. There has been relatively little attention to this important area, and less work on children's understanding of well-being.

Method:

This study uses a small-scale qualitative approach to consider how children understand well-being. Twenty school children took part in semi-structured interviews to elicit their definitions of well-being and the thoughts, feelings and beliefs associated with life going well. The interviews were analysed using Interpretative Phenomenological Analysis.

Results:

Four main themes were developed from the interview data: 'self', 'self in relation to others', 'growing up' and 'the role of adults'. These were presented, illustrated with verbatim quotation from the interviews. The four themes could also be brought together under an overarching theme of self-definition. A wide range of definitions and thoughts, feelings and beliefs were generated by children in the interviews.

Discussion:

Children's definitions of well-being in this study reflected a more holistic definition, incorporating elements of social, emotional and physical well-being. Well-being was *not* understood solely in terms of an 'absence of illness'. There was some overlap with other recent conceptualisations of well-being. This is discussed in relation to the promotion of children's mental health and well-being in different settings, the development of treatment goals, and the role of the positive within psychology and other services.

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Oh! and finally ... to the wonderful Web that has made finding and communicating with others working in related fields much, much easier

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INTRODUCTION

1. INTRODUCTION

1.1. HEALTH AND MENTAL HEALTH

All humans are both physical and mental beings (with both physical and emotional needs). However, the term mental *health* is more often associated with illness and is generally perceived in a negative light (Mental Health Foundation (MHF), 2002).

With increasing awareness of the links between mental and emotional health and well-being, and physical health problems, the promotion of mental health has become a key element of UK public health policy (DoH, 2000; 2001a). However, definitions of physical and mental health have traditionally been based on deficit models, where health is the absence of objectively diagnosable disease. This has implications for measuring and promoting mental health and well-being.

A recent survey reported that 10% of 5-15 year olds in the UK had a mental disorder (Meltzer, Gatward, Goodman & Ford, 2000), and it has been estimated that up to 20% will be experiencing psychological problems at any given time (MHF, 1999).

With only a small percentage of these accessing specialist child and adolescent mental health services (CAMHS), improving children's mental health in the wider population has also become a priority. The recent 'Bright Futures' report concluded that children's well-being and mental health needs wider recognition, with children's contribution and roles valued (MHF, 1999).

There is a lack of clear definition for what constitutes well-being in children.

McCulloch, Huebner & Laughlin (2000) suggest that psychologists have recognised the importance of promoting positive mental health and adaptation in children in addition to treating established mental disorders. However, the literature remains disorder-focused, emphasising the remediation of negative characteristics over and above promoting the positive (Schatte, Gillham & Reivich, 2000). This has implications for the development of population-based approaches and work with children and families across different services.

With a lack of published work in this area, the current study was interested in how children themselves understand 'well-being' and what it means to be well. This introduction aims to provide an overview of well-being and positive mental health, with specific reference made to children. Different ways of conceptualising these

ideas will be presented and discussed. The clinical implications of focusing on a definition of health and well-being (beyond an absence of illness or distress) will be also be considered. This will be followed by a description of the current study and research questions.¹

1.2. WHAT DOES IT MEAN TO BE WELL AND FUNCTIONING?

The question of what constitutes a 'good life' or one well lived has been asked for at least 2,000 years – dating back to Socrates' original philosophical question: 'how should we live?', and Aristotle's concept of 'eudemonia' or flourishing (Ryff & Singer 1998; Bowling & Windsor, 2001). While the question 'do I feel well?' appears a relatively simple one (Stewart-Brown, 2000), describing and defining the components of well-being is complex and covers many overlapping areas, such as life satisfaction, quality of life, and happiness (Andrews & Robinson, 1991).

Well-being has been associated with quality of relationships, good health, education and income (Deiner, 1999). The World Health Organisation's more holistic definition understands health as a 'state of complete physical, mental and social well-being and not merely the absence of disease and infirmity' (WHO, 1948, p.28). However, physical health has taken a more prominent role, with the impact of mental and social factors on health, disease, morbidity and mortality recognised more recently (Stewart-Brown, 2000). Again, when these have been considered, it is largely in relation to ill-being. Positive factors that promote individual well-being have received less attention.

Mental *health* (as noted above) has also been understood as an *absence* of illness. Seligman & Csikszentmihayi (2000) suggest this deficit model is less well equipped to focus on the positive end of the health spectrum. A lack of clarity in defining positive factors (Bowling & Windsor, 2001), as well as wider political and economic factors have further contributed. Difficulties that cause distress for both individuals and society require action, which has led to increased research (Fredrickson, 2000). The emphasis has been on the assessment and amelioration of problems rather than the presence of wellness (Ryff & Singer, 1996). Gillham and Seligman (1999) reported twenty-one articles on negative emotions for every one on positive

¹ To maintain the flow, definitions of terms used can be found in a glossary (*Appendix 1*).

emotions in the psychological literature. The resulting knowledge about disorders, environmental stressors and therapeutic techniques has benefited many individuals and families. However, Gillham and Seligman (1999) suggest this has been at the expense of understanding and improving positive mental health. Individuals become seen as passive: 'buffeted about by uncontrollable events' (Ryff & Singer, 1998, pg.18), where 'external reinforcements, weakened or strengthened responses ... and conflicts from childhood pushed us around' (Seligman & Csikszentmihayi, 2000, pg.6). This is reinforced by outcome measures that focus on 'dys'function (e.g. depression & anxiety inventories), and supported by disorder classifications such as the Diagnostic & Statistical Manual (APA, 1994). The goal of therapy becomes symptom reduction and mental *health* seen as a 'lack of distress' (Fava, 1999, pg. 171). In other fields, the emphasis has also been on the negative: those on low income or in 'at risk' groups within social policy; special educational needs in schools; using morbidity and mortality to gauge the functioning of populations in epidemiology. This only provides information about how 'ill' (or less ill) a population is, rather than how 'well' it is (Bartlett & Coles, 1998).

1.3. WHAT ATTEMPTS HAVE BEEN MADE TO UNDERSTAND AND MEASURE THE POSITIVE?

There have been attempts to recognise the role of positive factors within physical and mental health. These have been developed across a number of fields, although theoretical differences, overlap and a lack of clear definition can make it a frustrating area. While it is not possible to consider here the many theoretical models, a brief overview will be given of efforts to conceptualise the positive.

1.3.1. *Social well-being*

The impact of social factors on physical and mental health has increasingly been acknowledged, with social support and social networks found to be protective against disease and other difficulties (Larson, 1993; Stewart-Brown *et al.*, 1998; Carr, 1999). Within social science and health, there has been a growing awareness of the influence of social contexts on a range of health-related behaviours (Morrow, 1999). Recent Government publications have emphasised the important role of 'social environments' (where people know and trust one another) and the individual and group benefits of community involvement (DoH, 1998). The term 'social capital'

has recently been used to describe engagement, belonging, trust and support existing in these social networks within communities (Putnam, 1995). 'Social capital' offers a useful way to understand the presence of positive social processes, although Morrow (1999) recognised that as in health, the term risks being used as a 'deficit theory syndrome' (i.e. identifying factors that *unsuccessful* individuals, families and communities lack).

Individuals with experience of these social networks are reported to have higher self-esteem and self-efficacy – both associated with positive adjustment (Rutter, 1997; Morrow, 1999). The social context of children's lives will inevitably have consequences for their well-being – whether home, school or community. Family factors considered protective against problems include: clear roles within the family, father involvement and experience of a secure attachment (Carr, 1999). The importance of the school environment in promoting children's mental, emotional and social health and well-being has also been recognised (Rutter, 1987; Mayall, 1994; Weare, 2000). A 'whole school' approach to health education and promotion has been advocated in the UK (St Leger, 1999; Healthy School Standard, DfEE, 1999), and wider Europe (WHO's network of health-promoting schools, Rasmussen & Rivett, 2000). Such programmes emphasise equality, tolerance, relating to the reality of children's lives, and connections between school and the wider community. These factors, within a supportive environment, have been found to facilitate development, protect against difficulty and promote recovery if challenges are faced (Rutter, 1987; Carr, 1999).

Traditionally, social research has focused more on specific risk behaviours (e.g. drug and alcohol use), rather than the broader social context. Peer and friendship groups are seen as important but a larger number of studies consider their negative impact than the positive and supportive effects of group membership (Morrow, 2001). However, there have been increasing efforts to redress this balance as researchers acknowledge the contribution of issues such as resilience (successful adaptation despite adverse experiences) and social competence (the skills necessary to adapt to a range of social structures and settings), (DuBois & Felner, 1996).

1.3.2. Quality of life

Within physical health, there has been recent interest in 'quality of life' (QOL) as services become increasingly accountable for performance: comparing treatments, measuring outcome, resource allocation, and understanding patients' perceptions of the impact of illness/treatment (Schipper, Clinch & Olweny, 1996; Jenney & Campbell, 1997). Although QOL is often not clearly defined (Jenney & Campbell, 1997; Bowling & Windsor, 2000), this area does recognise the multi-dimensional aspects of functioning, and the importance of the individual's subjective perspective. However, scales developed still generally use negative (i.e. 'dis'ability) and functional (e.g. social role) items. While QOL represents an attempt to measure well-being, it is usually in relation to physical health (health related(HR)-QOL), and there is little consideration of subjective perceptions of strengths and gains (Ryff & Keyes, 1995). This is despite large individual differences in response and adjustment to pain, disability, and response to treatment (Huppert & Whittington, in press). The General Health Questionnaire (GHQ, Goldberg, 1979) does include positive ('been a happy person'), as well as negative ('lost much sleep over worry'), items, but does not score their presence.

With regard to children, HR-QOL is mostly used within acute services (e.g. paediatric measures of adaptation to chronic illness). Measures aim to cover children's social, physical and emotional development (Jenney & Campbell, 1997), but tend to focus on mobility, physical functioning and social activity. Recent attempts to include items of psychological functioning often measure these via behaviour and relationships (e.g. PedsQL questionnaire, Varni, Seid & Rode, 1999). As with adult measures, scales have been largely developed as outcome measures.

1.3.3. Subjective, emotional and psychological well-being

Attempts to measure the more subjective experience of positive psychological functioning have been located largely within social science and psychology, under the term of 'well-being' (again, with differing definitions). Objective factors have been used to consider 'well-being' (e.g. health, income, housing) in a 'bottom-up' approach, although these reportedly account only for around 15% of the variance (Deiner, Eunkook, Lucas & Smith, 1999). A more recent focus has been on individual factors (i.e. personality, goals, coping) and within clinical settings this

relates to ongoing work regarding resilience to risk and individual protective factors that promote adjustment (e.g. easy temperament, higher intellectual ability, self-esteem), (Garmezy, 1985; Rutter, 1987; Carr, 1999). *Subjective* well-being (i.e. happiness) further considers how individuals evaluate their own lives, and has distinct emotional components (positive and negative affect) and a cognitive component (life satisfaction), (Deiner *et al.*, 1999). Measures of subjective well-being have found low life satisfaction to predict mood difficulties and problems in social/occupational functioning (Deiner, 2000).

In relation to child and adolescent well-being, a similar tripartite model of subjective well-being has been used (life satisfaction, positive and negative affect), (McCulloch, Huebner & Laughlin, 2000). Measures of life satisfaction have been developed specifically for children (8-18 yrs), with reportedly good validity and reliability (e.g. Students Life Satisfaction Scale, Huebner, 1991). As in the adult literature, most children and adolescents view their lives in an overall positive manner, across different cultures (Huebner, Drane & Valois, 2000). A range of factors have been associated with life satisfaction: objective (life events, family relationships, gender); subjective (self-esteem, self-efficacy, locus of control, personality, social interest); behaviour and mood (correlating negatively), (Gilman & Huebner, 2002). However, there remains a lack of consensus about the key components of life satisfaction.

The validity of measuring well-being using happiness and life satisfaction has also been questioned (Ryff & Singer, 1998). Ryff (1989) criticised weakly articulated formulations that became 'standard bearers' of positive functioning. She developed a measure of Psychological Well-Being (PWB), with six dimensions - autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, self-acceptance. This conception was drawn from existing theoretical understandings of positive mental health and 'the good life' (e.g. Jahoda, 1958; Erikson, 1959; Maslow, 1968), philosophy (e.g. Russell, Mill) and sociology (e.g. Antonovsky, 1993). It has been validated on a large US adult population, with some reported correlation with existing well-being measures (Ryff & Keyes, 1995). There has been no published use of this measure with children or adolescents.

1.4. WHAT ARE THE PROBLEMS WITH HOW WELL-BEING HAS BEEN CONSIDERED?

The way physical and mental health have generally been conceptualised and understood is as an absence of 'ill-being'. Work specifically focusing on *well-being* is promising and represents an attempt to understand factors relating to the 'presence of wellness' (Ryff & Singer, 1996). However, one difficulty lies in the definitions used between (and within!) different areas. This, and the complexity of dealing with subjective experience, can lead to "woolly categories", as noted by Morrow (1999). This may offer some explanation as to why well-being has received less attention. As noted above, the social and health implications of negative functioning have also demanded more immediate attention and action.

A further difficulty with mental health and well-being is that descriptions highlight different key components, often reflecting the theoretical orientation underpinning the work (Huppert & Whittington, in press). Much research also occurs in the US, and is then used in the UK with limited consideration of population - and service - differences. Christopher (1999) further highlighted cultural differences in defining well-being and what constitutes a 'good life' between Western individualistic cultures (e.g. self as autonomous) and Eastern collectivist cultures (e.g. self *in relation to others*). The cultural and value assumptions at the heart of well-being may also explain why it has attracted less research - although classifications of disorders cannot claim to be value-free, despite their 'scientific' status.

However, there has been recent interest in positive factors associated with being well. Huppert and Whittington (in press) reported 'the difference between the absence of good feelings and the presence of psychological symptoms, is far from trivial', reporting differences in mortality between the absence of life enjoyment and satisfaction, and the presence of symptoms (anxiety/depression).² Clark and Watson (1991) also reviewed data on morbidity and reported cancer development was associated with *a lack of* positive affect rather than the *presence* of negative affect. If the presence or absence of well-being (rather than ill-being) provides additional information about psychological distress, but also a broader picture of overall human functioning, this information could be useful in developing measures and interventions to promote mental and physical health (Ryff & Keyes, 1995).

² Using positive scores calculated from positive items on the GHQ.

1.5. WHAT ARE THE CLINICAL IMPLICATIONS OF CONSIDERING THE POSITIVE?

1.5.1. *Assessment*

A focus on positive mental health relates to health promotion but also to literature and research focusing on risk and resilience, prevention, and adaptation (Carr, 1999; Ryff & Singer, 2000). All of the above have been considered in recent work within the US focusing on *positive psychology*. This has been conceptualised as operating at different levels (Gillham & Seligman, 1999; Seligman & Csikszentmihayi, 2000):

- subjective experience (well-being, contentment, hope/optimism, happiness)
- individual characteristics (e.g. courage, interpersonal skill, wisdom)
- group factors (e.g. citizenship, altruism, responsibility, tolerance).

In response to the research imbalance, Seligman (2001) and colleagues suggested working towards an “UN-DSM-I” – developing knowledge of positive strengths for use in research and intervention. As noted above, more is known about how negative emotions promote illness, than how positive ones promote physical and mental health. However, recent studies report positive emotions linked to increased attention and increased flexible/creative thinking (Fredrickson, 1998); reduced stress (Lovallo, 1997); and beneficial effects on the immune system (Salevoy, 2000). The role of optimism (Myers, 2000), hope (Snyder, 1997), and meaning in daily life (Debats, 1996) have also recently been discussed in the literature.

1.5.2. *Intervention*

In therapeutic work, an emphasis on the positive is not new. Parloff, Kelma & Frank (1954) suggested the goals of therapy were not only the reduction of symptoms but also an increase in personal comfort and effectiveness. However, in clinical interventions, it has been argued this is often implicit (Seligman, 2000).

One of the most widely used and reportedly effective range of interventions have been developed from the cognitive model (DoH, 2001b). Despite being based on Epictetus’ philosophical insights into the role of individual interpretation of events (rather than actual events) in relation to happiness, this model was developed from work with patients with anxiety and depression and is thereby rooted in dysfunction (Beck, 1976). Negative cognition (at three levels: thoughts, assumptions and beliefs)

has been reliably demonstrated to predict affect and behaviour, and this is where cognitive-behavioural intervention is focused. It has been suggested that Beck (1976) recognised that positive schemata or attitudes 'form the basis for a healthy personality adjustment' (p.276), but the role of the positive within the cognitive model has received less explicit attention (Lightsey, 1994).

The role of positive cognition received some attention in the late 1980's and early 1990's. Taylor & Brown (1988) reported positive thinking (even if illusory) enhanced mental (and physical) health and well-being. As positive and negative affect are reported to be independent, Lightsey (1994) found a similar relationship between negative and positive automatic thoughts. Here positive automatic thoughts were found to relate to both present and future happiness. Ingram and Wisnicki (1988) developed a Positive Automatic Thoughts Questionnaire (ATQ-P).³ Although the measure was used within clinical samples, it has not received wider recognition or discussion in the literature. The role and predictive value of positive cognition in terms of well-being has yet to be fully understood. However, recent work suggesting the benefits of optimism for mental and physical health, acknowledge these effects may be mediated at a cognitive level (Peterson *et al.*, 2000).

Seligman (2000, 2001) and others advocate a more explicit emphasis on the positive in preventative and therapeutic work - aiming to build strength rather than repair damage. Using a 'learned optimism', skills-based approach had a significant preventative effect for individuals 'at risk' of anxiety/depression: at three years for young adults (Seligman, Schulman, DeRubeis & Hollon, 1999), and two years for children (Gillham, Reivich, Jaycox & Seligman, 1995). Fava and colleagues (1998, 1999) also reported using a 'well-being enhancing psychotherapeutic strategy' (pg.172), and found it as effective as CBT in significantly reducing residual symptoms of anxiety and depression in adults (Fava *et al.*, 1998)⁴. In children the use of CBT has been increasing (Kendall, 1995; Carr, 1999), although as with adults the focus remains largely on the reduction of negative thoughts and beliefs. Kendall (2000) recently stated that 'theory suggests, and research evidence supports, that it is not so much the power of positive thinking related to emotional adjustment as the

³ To compliment the ATQ developed by Hollon & Kendall (1980)

⁴ The approach combined Ryff's (1989) six domains of psychological well-being with cognitive-behavioural techniques to form Well-Being Therapy (WBT) .

absence of non-negative thinking' (pg.21). However, there has been little attention to the role of positive cognition in either clinical or non-clinical samples. Ryff and Singer (1998) also note a lack of studies on the interpretation, thoughts and beliefs associated with everyday, positive events.

1.6. HOW IS WELL-BEING AND MENTAL HEALTH CONSIDERED IN CHILD WORK?

1.6.1. *Defining children's mental health*

Despite the growing recognition of the importance of promoting children's well-being (MHF, 1999), literature searches for this study revealed less published work relating to well-being and positive mental health than for adults. This is an omission for two reasons:

- if work in this area has important clinical implications, children should also benefit
- if the role of emotional and psychological factors in health and well-being are rooted in early experience, interventions need to target adults *when they are children*

The NHS Health Advisory Service (HAS, 1995) suggest key elements in children's mental health: a capacity to enter into and sustain mutually satisfying personal relationships; continuing progression of psychological development; an ability to play and learn so attainments are age appropriate; a developing moral sense of right and wrong; the degree of psychological distress and maladaptive behaviour being within normal limits for the child's age and context. This is similar to the general definition given by the Mental Health Foundation (2002), and reminiscent of the holistic definition of health by the WHO (incorporating emotional, social and physical well-being). Such definitions conceptualise mental health as 'something of an ideal state which all struggle to attain' (HAS, 1995, pg. 15). How then, is this 'ideal state' considered in current clinical practice?

1.6.2. *Assessing children's well-being and mental health*

In 1980, the US RAND Study (Eisen, Donald, Ware & Brook, 1980) reported apparently little attempt to define or incorporate child mental health into existing measures. Physiological, physical and behavioural symptoms were used at the expense of a more balanced picture (including positive *and* negative feeling states). Although there has been a development of measures and the use of these with

children (e.g. life satisfaction), this has been more in research than routine clinical practice. As with adults, children's functioning is mostly measured by an absence of difficulty and distress (e.g. child behaviour checklists, anxiety and depression scales). An example from the Children's Depression Inventory (Kovacs, 1981) gives three responses: 'I look ugly', 'There are some bad things about my looks', 'I look ok'. This reflects the deficit model, with no opportunity to give a positive response (e.g. 'I look great'). As discussed above, '*optimal* mental health is *not* equated with the *absence* of psychopathology' (Huebner & Gilman, 2002) - so why are measures of the 'ideal state which all struggle to attain' largely missing? (Bartlett & Coles, 1998).

Recognising the limitations of existing measures, the Strengths and Difficulties Questionnaire (SDQ, Goodman, 1997) aims to 'emphasise children's strengths and not just their deficits' (pg.581). It has been well validated and is widely used, with age-related self-report questionnaires and parent/teacher forms. However, although the SDQ incorporates strengths, it does so only in behaviour and social relationships. Items addressing affect are negative (i.e. unhappy, fears, worries) and there is no specific reference to positive feelings or beliefs held by children.

Goodman (1999) further acknowledged (as Bartlett & Coles, 1998) that clinical cases are identified only when symptoms are severe enough to access services (Meltzer *et al.*, 2000). There has therefore been a wider recognition of the need to promote positive mental health and adaptation in children (McCulloch *et al.*, 2000). In response to this, many programmes and interventions have been developed within local education and/or primary care services, often involving psychologists (e.g. PATHS, Promoting Alternative THinking Strategies, Appleton & Hammond-Rowley, 2000). At a national level, this work has been recognised and supported by recent reports (MHF, 1999; DoH, 2001), and the development of wider population-based interventions (e.g. SureStart in the UK), (DfEE, 1999). Such programmes have their root in earlier US interventions developed in the 1970's (e.g. Headstart, Homestart, Even Start). These found that programmes involving parents had greater impact. Such interventions represent an attempt to move 'beyond treating and preventing problems that stem from negative emotions and into the realm of building personal strength, resilience and wellness' (Fredrickson, 2000, pg.10).

The contribution of these initiatives requires evaluation to consider how effective they are in promoting children's development and well-being. As discussed, existing outcome measures are limited. At the time of writing the researcher was aware of two measures being developed – by the Royal College of Paediatrics and Child Health, and the Government's 'Children and Young People's Unit'. Although both discuss the importance of including items about psychological factors, positive mental health and well-being, draft proposals acknowledge the difficulty of specifying and measuring these (Buchanan, 2002, personal communication).

1.6.3. *Asking children about health and well-being*

As noted in the recent Bright Futures report (MHF, 1999), children are more likely to be asked their opinion now than in previous generations. Both outcome measures currently being developed will collect information directly from children and parents. However, there is relatively little published material relating to children's understanding of this area. More studies have reported children's understanding of physical health (Bibace & Walsh, 1980; Bird & Podmore, 1990; Normandeau, Kalnins, Jutras & Hannigan, 1998). In literature searches conducted for the current study, one paper specifically focused on children's understanding of positive mental health. Following an analysis of 5-12 year old Canadian children's beliefs about health, Jutras, Normandeau, Kalnins & Morin (1998), developed categories relating to mental health referents. They identified seven dimensions - social support, harmonious interpersonal relationships, expression of positive emotions, school involvement, high morale, relaxation, non-specific mental health - suggesting 'mental health was an integral part of children's general concept about health' (pg.21).

As discussed, there has been recent recognition of the importance of developing and evaluating interventions that prevent difficulties and promote physical and mental health in children. The lack of specific work on children's beliefs and understanding about *mental* health therefore seems an omission. There may be some overlap between children's understanding of well-being and positive functioning, with the limited research conducted with adults (e.g. Ryff, 1989), but it cannot be assumed they are the same. Gilman and Huebner (2002) reported 13,500 articles relating to depression/anxiety in children and adolescents, compared to 250 for happiness.⁵

⁵ Using PsychInfo, since 1887.

Understanding children's conceptions of well-being would balance existing knowledge. Such information could be useful in developing outcomes measures of positive health for evaluating community programmes. In direct work with children, a greater awareness of individual definitions of what it *means* to be well could also be valuable in establishing treatment goals and targeting interventions.

1.7. CURRENT STUDY

The current study started from a recognition of the lack of literature considering how children conceptualise well-being and positive mental health.

1.7.1. *Research aims and questions*

This research study was designed to elicit children's descriptions and understandings of well-being, and the thoughts, feelings and beliefs they associate with life going well. Given the lack of a theory or measures relating specifically to well-being in children, this exploratory study examined the subjective experiences of a small, non-clinical sample of individuals.

This study was also influenced by the researcher's own interests and experience, and from working with children in a range of settings (schools, youth clubs, acute and mental health settings). From previous research experience, the researcher believed children would be willing to take part and be able to talk about well-being, if they received information about the study that made sense to them, and felt comfortable and able to contribute. After three years training in clinical psychology, where there is an inevitable emphasis on 'dys'function, the researcher also wanted an opportunity to focus specifically on ideas relating to *positive* mental health.

The following research questions were formed:

- Can children describe what well-being means to them?
- Will children's definitions of well-being consist of more than 'an absence of illness'?
- What feelings, thoughts and beliefs do children have when things are going well?
- What do children feel helps them to stay well – and how does this relate to our current understanding of well-being and mental health?

METHOD

2. METHOD

2.1 DESIGN

2.1.1 *Rationale for method used*

The aim of this exploratory study was to provide a detailed account of children's understanding of well-being, and associated feelings, thoughts and beliefs. The choice of method within psychological research should reflect the theoretical rationale behind the study, the needs of participants and ethical considerations (Henwood & Pidgeon, 1995). With little research conducted into the above area, a qualitative approach was considered most appropriate – using an in-depth study of a small sample. These methods allow the researcher to examine questions differently to traditional approaches (Coolican, 1999). The exploratory nature of this study focuses on uncovering individual meaning and understanding as opposed to testing fixed hypotheses resulting in generalisable findings, based more on a positivistic scientific approach (Henwood & Pidgeon, 1995; Mays & Pope, 1999).

Qualitative methods are inductive and aim to look at the ways meaning is constructed so that if developing theory, it is grounded in participants' personal experiences. This represents a more constructivist approach, acknowledging the existence of multiple perspectives which are socially constructed, as opposed to any 'objective' truth (Burr, 1995). Children will have differing, individual understandings of well-being, which relate to a range of experiences and to which they will ascribe different meanings. However, there may also be common themes and experiences that can be identified and of use in health promotion, clinical services or other settings. Without a clear body of literature relating to children's understanding of well-being, it was considered an important first step to collect a range of individual, subjective views from a non-clinical sample – to hear directly from children themselves.

2.1.2 *Method of analysis*

The type of data collected influences the selected methodology and analysis. There are different methods of qualitative analysis and this study used semi-structured interviews, providing textual data (Fielding, 1993). The interview has been considered particularly useful for building understanding of children (Parker, 1984). The researcher was interested in individual perspectives, as well as searching for commonalities in the data. An approach such as grounded theory (Strauss & Corbin, 1998) could have been used for this purpose but was not selected as this study did not aim to generate theory. The researcher also wished to use a methodology that more explicitly acknowledged the role of the researcher and their impact on the research process.

For these reasons, the selected method was Interpretative Phenomenological Analysis (IPA, Smith, 1996; Smith, Osborn & Jarman, 1999). This method has been developed and used largely within health psychology. It perceives the research process as dynamic and recognises the researcher's presence as impacting on the experience and behaviour of participants. An assumption of IPA is that meanings are interactional and the position of the 'interpreter' is central (hence, the 'interpretative' element). Within this methodology an attempt is made to understand the world from the position of the 'other', from an observer perspective. IPA also focuses on participants' beliefs and their attempts to make sense of meanings, events, and experiences within the context that participants provide them (Smith, 1996).

2.2 PARTICIPANTS

Three pilot interviews were conducted, followed by individual interviews with 20 school-children between the ages of 10-11 years of age (Year 6). Children of a specific age were selected to reduce variation in terms of cognitive development. Year 6 pupils were felt to be old enough to provide valid self-report but not yet immersed in the developmental tasks associated with adolescence.

Participants were recruited from five schools (local primary/ middle schools in Oxfordshire). Equal numbers of males and females were randomly selected from class registers.⁶ These children were invited to participate, and received an information sheet and consent form (*Appendix 2*). Parents also received their own version, and both consent forms were required to be completed. Table 1 provides information about schools and participants.

Table 1: Schools and participants involved in the study.

School	Type	Sent out	Number interviewed	Male/ female
A	County C of E Primary, outskirts of Oxford	10	9 (90%)	4/5
B	County C of E Primary, small village	8	5 (62%)	2/3
C	County C of E Primary, mid-size village	5	2 (40%)	1/1
D	County Middle School, City, council estate	5	2 (40%)	0/2
E	County R C Middle School, City residential	5	2 (40%)	0/2
TOTAL		33	20 (60.6%)	7/13 (35/65%)

2.2.1 Sampling

Qualitative approaches do not *require* a representative approach to sampling, but it was hoped that using a number of schools would provide a wider sample of different social and educational backgrounds. In practice, most participants came from two schools, due to their high response rate.

⁶ Teachers were asked to select every sixth name from the register until they had the names of three girls and two boys – or two girls and three boys.

2.2.2 Inclusion and exclusion criteria

Participants were randomly selected from class registers of Year 6 pupils but teachers were asked to exclude those known to be involved with specialist services (social, health or educational) or where there had been recent life events (e.g. parental divorce, bereavement). The reason for this was not to place an additional burden upon these children and their families.

2.2.3 Participant characteristics

Twenty children (and parents) returned consent forms and all were interviewed. Participant characteristics are shown in Table 2.⁷

Table 2: Characteristics of pilot interviewees and participants.

Participant	Sex	Age	
1	Female	10 yrs	Pilot
2	Female	11 yrs	Pilot
3	Female	12 yrs	Pilot
Participant	Sex	Age	School
4	Female	11yrs,1mth	A
5	Female	10yrs,9mths	A
6	Male	10yrs,11mths	A
7	Male	11yrs,1mth	A
8	Female	10yrs,9mths	A
9	Female	10yrs,5mths	B
10	Female	10yrs,3mths	D
11	Female	10yrs,8mths	E
12	Female	10yrs,5mths	B
13	Female	10yrs,4mths	E
14	Male	10yrs,8mths	B
15	Female	10yrs,10mths	B
16	Female	10 yrs,9mths	A
17	Male	11yrs,3mths	A
18	Male	10yrs,9mths	B
19	Male	10yrs,10mths	A
20	Female	11yrs,3mths	C
21	Female	10yrs,5mths	A
22	Male	11yrs,0mths	C
23	Male	10yrs,11mths	D
	Age range:	10yrs,3mths-11yrs,3mths	
	Mean age:	10yrs,9mths	

⁷ Participants listed in the order in which the consent forms were returned and similar to order of interviews (except No's 11, 13, 20, 22 – these were last interviews conducted).

2.2.4 *The interview*

A semi-structured interview was considered appropriate for the research aims of this study. It is widely used to elicit individual views and beliefs (Smith, 1996). In terms of collecting this information, Parker (1984) referred to the importance of the 'personal relationship which results from the physical presence in the same setting of both interviewer and the respondent' (p.19). Due to the lack of research in this area, the researcher also wanted to allow participants to express their views as freely as possible. Having some structure was important as it enabled the researcher to facilitate discussion, given that participants were children and some would be more articulate than others. However, there was flexibility to respond to the feedback of individual participants (Fielding, 1993) and to allow 'conversations' to develop (within the constraints of time and setting). Effort was made to develop rapport with participants and to respond sensitively to topics they chose to discuss. A social constructionist style of interviewing was used – being 'curious' about participants' answers to encourage clarification and elaboration (Cecchin, 1984).

The interview schedule was designed to address the research questions described above, drawing from relevant literature, and the interests and experiences of the researcher. Issues of cognitive development relating to this age group were also considered (Parker, 1984). Three pilot interviews were conducted and feedback from these contributed to the development of the schedule. The final interview schedule (*Appendix 3*) began with an unstructured opening section, becoming increasingly structured throughout. Visual and verbal prompts were also used. The interview lasted between 45-60 minutes (considering concentration span, time away from class and transcribing time required for interviews). The interview schedule and procedure are described below:

A. Pre-interview briefing

Participants' understanding of the information sheet was checked. Confidentiality and anonymity (of personal details and audio-tape recording) were explained. Participants were given the opportunity to ask questions or raise concerns, and told they could stop at any time. Effort was taken to explain that individual views and ideas were wanted - there were no right or wrong answers, and it was okay to ask questions or say 'I don't know'.

B. Background information

Using the consent form, personal details were checked, leading to general conversation about school and interests to develop rapport.

C. Part one

Participants were asked to rate 'how things are going' on a scale from 1 to 10 (as an initial easy question and rough guide to current functioning, *Appendix 4*). This was followed by an open question, asking participants what they thought the words: 'well-being', 'wellness', and 'being well', meant to them (*Appendix 5*). Participants were encouraged to talk about their responses and give examples.

D. Part two

This section focused on two situations. Participants were first asked about the most recent time they felt things were going well/ good/ life was going okay. This grounded discussion in the context of participant's daily lives (Kalnins, Jutras & Normandeau, 1998). Questions about feelings, physical sensations, thoughts and beliefs were asked to elicit those associated with well-being and things going well. This was then contrasted with a time when things were *not* going so well, to compare responses. Again, visual prompts were used to help participants understand what was being asked (*Appendices 6-9*).

E. Part three

Participants were asked to consider what helps (their 'top tips') *them* to stay well; to give advice to *someone their age*; and suggest how *adults* could also support them in this (*Appendix 10*).

F. Feedback and debrief

Participants were asked for feedback on taking part in the study. Anonymity was re-visited and any questions answered before participants were thanked for taking part and returned to class. The researcher then noted thoughts or reflections about the interview.

Following this, letters were sent to schools (*Appendix 11*), with certificates to thank participants for their contribution (*Appendix 12*).

2.3 ETHICAL CONSIDERATIONS

Ethical approval for this study was given by the Oxford Applied Qualitative Research & Ethics Committee (AQREC, *Appendix 13*). An ethical approach was used throughout the recruitment and collection of data.

A. Selection

Careful consideration was given to the involvement of children in this study. Schools were asked to exclude children known to be experiencing current difficulties.

B. Information sheets and consent forms

Both children and parents received separate versions. An effort was made to provide clear details of the study and address children in a developmentally appropriate, but fun way. Signed consent from both children and a parent/guardian were required to take part in the study.

C. The interview

Interviews took place in a room familiar to participants, near a school office or classroom, with teachers aware interviews were taking place. Due to a priori power relations between children and adults, confidentiality becomes particularly important (Parker, 1984). Issues of confidentiality were carefully explained and understanding checked. During the interview, participants could choose which situations they discussed, and could stop the interview if they wished. If difficulties were disclosed, the researcher would have been sensitive to individual concerns and encouraged participants to talk with a trusted adult (e.g. class-teacher) – although this did not occur. Trust child protection policies were observed at all times. Both participants and Head Teachers were encouraged to contact the researcher if they had questions or concerns about the study.

D. Data security

Consent forms returned by participants were numbered and these numbers were written on the audio-tapes. Audio-tapes and personal details were then kept separately.

2.4 DATA ANALYSIS

Interview data was analysed using IPA (Smith, 1996), an approach interested in individual perspectives. Analysis is focused at this level, before looking for patterns across cases (Smith *et al.*, 1999). Steps in the process of analysis are described below:

A. Transcribing

Audio tapes were listened to and notes made.⁸ All audio-taped interviews were then transcribed in full and checked through by the researcher.

B. Coding

With IPA, there is an initial focus on one transcript.⁹ The transcript is read several times to increase familiarity with the text. Preliminary thoughts are noted in the left-hand margin. The right-hand margin is then used to document emerging themes within the data (*Appendix 14*).

C. Developing themes

Themes were transferred to a separate sheet and the researcher sought connections between them to develop super-ordinate themes. Other transcripts were then examined for these themes. New themes emerging during this process were checked back against previous transcripts. Themes were then organised in relation to each other and examples identified. This process was ongoing, and looped back and forth in an effort to continually return to and reflect on the original data.

D. Presentation of data

The data was presented in terms of the themes emerging from the interviews, supported and illustrated by verbatim quotation. Some data was also presented in the naturally forming categories from the interview (i.e. feelings and thoughts). Effort was then made to place findings within the context in which the study took place, and the current literature. It was important to consider work relating to well-being, the cognitive model (as this framework influenced questions on thoughts, feelings and beliefs), and children's mental health (intervention and promotion).

⁸ A quarter of interviews were transcribed by the researcher, the rest paid for to focus time on analysis. All transcripts were checked by listening to original audio-tape interviews.

⁹ This transcript No. 17 was randomly selected from those typed by the researcher

2.5 RELIABILITY AND VALIDITY

Qualitative methods aim to analyse first person reports, exploring gaps left by quantitative approaches and taking account of the context in which data is produced (Mays & Pope, 1999). They have been criticised for a lack of scientific rigour, where the two central tenets of rigorous research are considered to be reliability (apparent consistency and replicability of observations) and validity (generalisable truths of statement), (Silverman, 1993). Given that qualitative methodology is concerned with meaning and subjective experience, traditional ways of assessing reliability and validity have been considered less relevant – and are rejected by some (Mays & Pope, 2000). However, it remains important for those using qualitative work to be sure research reaches a certain standard – that it is trustworthy, aware of its own biases and thorough in its use of a method. In an effort to demonstrate this, the following established principles were used to guide the research process:

A. Researcher bias and Reflexivity (Smith, 1996; Coolican, 1999)

The researcher should make every effort to be aware of and reflect on their own biases and assumptions. A statement of experience and interests was given in section 1.6.1 above. As self-reflexivity enables a researcher to pay close attention to the participants' *own words*, a research diary was also kept throughout the research process (*Appendix 15*). This diary was used to track thoughts and feelings about the study and to record ideas over time. In addition, advice and support was deliberately sought from individuals with a range of specialist knowledge (social policy, clinical psychology and public health medicine). It was hoped this would result in a more thorough consideration of findings and their wider implications.

B. Respondent validity (Mays & Pope, 1999) or *Member validation* (Smith, 1996)

This considers the extent to which the researcher's analysis and interpretation of data reflects the experiences and realities of individual participants. Themes can be fed back to participants to ask if these reflect their original views, although Smith (1996) argued that inherent power relations may make it difficult for participants to disagree with an interpretation. Initial themes regarding well-being were sent to nine participants from one school and all were returned with comments suggesting they were recognisable (*Appendix 16*).

C. Auditability (Stiles, 1993) and *Internal coherence* (Smith, 1996)

The research process should be made explicit so that it can be clearly followed. For this reason, a detailed account of IPA was given in sections 2.1.2. and 2.6., and will be considered in section 4.2.2. The research diary also provides an account of the research process. Using an approach such as IPA, themes and conclusions can differ according to individual researchers' analysis of the data set. It should therefore be possible for any individual to track back from the themes to the text to consider whether the analysis is internally consistent and coherent.

D. Consensus of themes (Coolican, 1999)

Besides providing a clear explanation of the research process, the question should be asked: are the researcher's interpretations consistent with the data? A colleague followed a full transcript to check the themes present in this, and then followed a main theme through sample transcripts to check for consistency of this theme. The purpose was not to see whether the individual agreed with the themes but whether these were consistent and could be followed.

E. Presentation of evidence (Smith, 1996) or *Rhetorical power* (Henwood & Pidgeon, 1995)

The reader should be able to take part in an 'interpretative dialogue' with the data. Their reactions to the interpretations of the researcher then act as a check on validity. Enough information should be provided to consider alternative interpretations of the data. In the current study, verbatim quotation from interviews was used to clarify and support themes (although this was constrained by word limits).

F. Attention to negative cases (Coolican, 1999; Mays & Pope, 1999)

As well as considering alternative interpretations of the data, effort should be made to consider elements that contradict (or appeared to contradict) the emerging interpretation. This is considered another way to reduce error (Mays & Pope, 1999). Examples from data that did not 'fit' initial themes of this study were kept to one side, so that further development of themes considered these as far as possible.

G. Generativity (Henwood & Pidgeon, 1995) or *Relevance* (Mays & Pope, 1999)

As with all research, it is important to consider qualitative research in terms of its relevance, contribution and potential clinical implications, as well as future research. These will be considered and discussed in section 4.

RESULTS

3. RESULTS

Using Interpretative Phenomenological Analysis (Smith, 1996), the overall aim is to develop and present themes in the data. These themes will be discussed in section 3.3, with details of how many times and where these themes occur in each interview transcript given in *Appendix 17*. However, some ‘natural’ categories were also formed by specific questions asked during interviews. These categories are related to the main themes, although due to space constraints will be summarised below before considering the data as a whole.

3.1. WHAT DO CHILDREN SAY WELL-BEING IS?

In the first part of the interview, participants were asked specifically to consider the meaning of ‘well-being’, ‘wellness’ and ‘being well’. The ideas and definitions generated were categorised and checked with 9 participants from one school, who felt these were representative of their views. One comment was: ‘I think you set it out very clearly and the way you put it into sections was very helpful’ (participant 4).

Descriptions of wellness and well-being most often referred to the individual. The idea of ‘**being myself**’ was reported by most participants to have *both* physical and emotional components.

a. With regard to *physical well-being*, the majority of participants described :

- the absence of illness: where ill is ‘being at home’, ‘sick’, ‘weak’, ‘can’t do much’, ‘bored’, ‘horrible’
- body working well: ‘healthy’, ‘well’, ‘strength’, ‘not weak or ill’
- health-promoting behaviours/looking after yourself: ‘cleaning your teeth’, ‘eating well’ (e.g. ‘not lots of chocolate’), ‘being fit’, ‘not doing dangerous things’

Being physically well was important because it allowed participants to *do* things and be active (‘have a laugh’, ‘going places’, ‘try new things’, ‘going to school’). However, participants were as likely to report thoughts and feelings relating to other aspects of well-being.

b. With regard to *emotional well-being*, most participants described:

- being myself: 'not trying to be someone else', 'being happy with who you are'
- positive feelings: 'playful', 'enjoying life', 'happy', 'feeling free/up to things', 'relaxed'
- the absence of negative feelings: 'not sad' (or upset/down/regretful), 'not cross', 'not worried about things at the moment'
- how you are in yourself: 'you are doing alright' (at home, at school), 'nothing is wrong' (e.g. being bullied)
- thoughts about future: ('doing well', 'getting grades to get a good job')

Other factors considered important for individual well-being were:

- having opportunities and new experiences, learning new skills
- achievement (meeting goals, recognising success)
- some independence & choice (going places with friends, saving own money)
- a sense of security (your own home, money, feeling safe)

c. As well as describing *physical and emotional* aspects of well-being and 'being myself', participants often reported the importance of others – *social* well-being.

- negotiating relationships: 'getting on', 'being involved' with peers & family
- supportive & reciprocal relationships: 'love', 'sharing', 'trust', 'helping'
- social rules, expectations & comparison: 'being good', 'doing as you are told', 'not being left out'
- shared activities: 'playing', 'doing things' with friends and family
- having good things happen: 'being told you've done well', 'having surprises'

Overall, participants referred to physical, emotional and social aspects of well-being.

3.2. WHAT ARE CHILDREN'S FEELINGS AND BELIEFS ABOUT BEING WELL?

In part two of the interview, participants were asked about a time when things were going well and a time when things were not. They reported a wide range of situations, from different periods of their lives, and across various settings:

- at school – recently (e.g. doing well, being punished that day) and some time ago (e.g. friendships in a previous class).
- at home – recently (e.g. fights with siblings; helping at home) and in the past (e.g. Christmas Day; a bereavement, age 5).
- other settings – e.g. passing tap-dancing exam, going into town with friends, playing computer games, seeing film with family.

3.2.1. FEELINGS AND BODY SENSATIONS

Participants generated a wide range of feeling words relating to both positive and negative situations (with some cross-over of 'positive' and 'negative' feelings in each) and insightful descriptions of the bodily/physical sensations accompanying these feelings.

See Table 3 below.

3.2.2. THOUGHTS AND BELIEFS

Participants also generated thoughts and beliefs relating to each situation, although some found this more difficult than others. The number of thoughts were too numerous to present but were used to elicit beliefs participants held about themselves (again, without a clear distinction between 'positive' and 'negative' situations – i.e. positive thoughts were not just elicited from positive situations).

See Table 4 below.

Table 3: Feelings and physical sensations reported by participants

	<i>Associated with things going well</i>	<i>Associated with things not going well</i>
<i>Feelings</i>	happy, joy(ful), excited, really good, excited, pleased with myself, confident, really chuffed, open, enthusiastic, can't wait, caring, shy, surprised, friendly, helpful, proud, nice, love/loved, useful, liked, glad, relieved, good mood, life's good, great, wahey!, can do it, special, bubbly, relaxed, <i>plus less apparently positive feelings</i> : quite scary, shocked, disappointed, daunted, nervous, sorry, sad, worried (re. others), tired	sad, angry/annoyed, scared, irritated, really bad, upset, emotional (bit soppy), sorry, hurt, silly, stressed, cross, depressed, confused, shock, lonely, empty, oh no!, regret, left out, bored, fed-up, frustrated, down, desperate, mad, worried, disappointed, unhappy, loss, guilty, bit horrible, 'Doh!', not really in a mood, bad memories coming back, <i>but also</i> confident, surprised
<i>Body sensations</i>	<i>increased physical activity</i> : stamping feet on floor, wanting to scream/run/jump about, arms move <i>physical reactions</i> : goose bumps, smiling, stable (not shaking), tummy sticks out, arm muscles tense, weight off (shoulders), feeling 'lifted up' <i>internal physical sensations</i> : a 'warm' / hot feeling, 'hot shock round heart', 'like a fire lights up in you', tickling in tummy/chest, churning or 'bubbly' tummy (opposite to upset tummy) <i>mental activity</i> : conscience/head tells you things (e.g. back off/encouraging), feels good, like nothing bad happened), spirits lifted ('all gone up')	<i>decreased physical activity</i> : slump in chair, lazy (body not feeling up to things) <i>physical reactions</i> : bugging feeling on back, arms folded, muscles tense, no smile, pursed lips, frown, stomach droops, shaking, head (pounding) <i>internal physical sensations</i> : bit sick & horrible in tummy, dizzy, heart/throat 'choked up', 'like a mouse tickling throat dry', chest churning (diff. to happy), 'crunched up', small('in your toes') <i>mental activity</i> : things go round & round in head, brain tingles or something says 'it'll be ok', 'see red', vacant/empty, switched off, half ok-half stropic, self-aware

Table 4: Participants’ beliefs elicited from thoughts about the situations

	<i>When things were going well</i>	<i>When things were not going so well</i>
<i>Individual characteristics and skills</i>	<p>I am someone who tries</p> <p>I look forward to my future</p> <p>I am quite dedicated</p> <p>I am a wishful thinker</p> <p>I always do my best</p> <p>I am a happy person</p> <p>I can learn to do things</p> <p>I can rely on myself</p> <p>I celebrate my achievements</p> <p>I try new things</p> <p>I am good at games</p> <p>I am clever</p> <p>I work hard</p> <p>I am doing well</p>	<p>I am thoughtful</p> <p>I am hard-working</p> <p>I don't give up</p> <p>I am quite calm (take it as it comes)</p> <p>I care about my work/job/future</p> <p>I'm someone who stays out of trouble</p> <p>I am quite emotional</p> <p>I am a negative person</p> <p>I think before I speak</p> <p>I think hard about things</p> <p>I don't think before I speak</p> <p>I get cross easily</p> <p>I can get stroppy</p> <p>I always think I'm right</p> <p>I get annoyed inside</p>
<i>Individual fears and concerns</i>	<p>I'm nervous of things going wrong</p> <p>I'm a worrier/picky/fussy</p> <p>I'm nervous about new situations</p> <p>I am nervous about people laughing at me</p>	<p>I am a worrier</p> <p>I think and worry a lot</p> <p>I don't like/mean to hurt others</p> <p>I feel helpless (want to give up)</p> <p>I can get worked up (and don't know what to do for the best)</p>
<i>How individuals are with others</i>	<p>I am caring/loving</p> <p>I am helpful</p> <p>I think of/help/protect others</p> <p>I am kind</p> <p>I am grateful/happy for others</p> <p>I am sociable/friendly</p> <p>I try & get on with people</p> <p>I love my family</p> <p>I want my family to have the best</p> <p>People can rely on me</p> <p>My friends can turn to me</p>	<p>I am caring</p> <p>I am someone who cares</p> <p>I think about others I care about</p> <p>I am generous</p> <p>I am a generous person/say sorry</p> <p>I am trustworthy</p> <p>Others can rely on me</p> <p>I can be self-centred/mean/nasty</p> <p>I can get annoyed with others</p>
<i>What individuals want/need from others</i>	<p>I like people to notice me/be liked</p> <p>I don't like being told what to do</p> <p>I like to stick to people I know well</p> <p>I don't like to be alone</p> <p>I am happier with s'one than alone</p> <p>I need others to tell me I'm doing okay</p>	<p>I like to be told the truth/to be kept informed</p> <p>I have an opinion & want to be heard</p> <p>I like to be with friends</p> <p>I don't like to be rude</p> <p>I don't like being responsible on my own</p>

3.3. WHAT ARE THE OVERARCHING THEMES GENERATED WITHIN AND BETWEEN INTERVIEWS ABOUT WELL-BEING?

Themes relating to well-being ran throughout the interviews. Four super-ordinate themes were developed, with 10 themes and 17 sub-ordinate themes (see Table 5 below). All twenty interviews were used to develop the themes which will be discussed below (for further detail of individual themes present in each interview transcript, see *Appendix 17*).

Table 5: Themes developed from the interview data.

<i>Super-ordinate theme</i>	<i>Themes</i>	<i>Sub-ordinate themes</i>
1. Self	a. Activity	i. physical ii. mental iii. have a go at things iv. inactivity v. relaxation
	b. Attitude to self	i. certain of self ii. uncertain of self
2. Self in relation to others	a. Being yourself	
	b. Shared activity	i. friends ii. family
	c. Negotiating relationships	i. being involved ii. rules and expectations iii. siblings iv. expressing feelings v. source of support vi. reciprocity
3. Growing Up	a. Increasing abilities	i. independence & autonomy ii. understanding complexity
	b. Sense of responsibility	
	c. Limitations & constraints	
4. Role of Adults	a. Recognition of individuality	
	b. Support & encouragement	

Despite limited time, a new situation and standardised questions, throughout the interviews the researcher was aware of each individual participants' personality. This was related to an *overarching theme* of self-definition ('who I am...') that pervades all four super-ordinate themes above. Many dilemmas and contradictions were associated with this and could be seen to impact upon individual well-being.

3.3.1. Self

a. Activity

The theme of activity was present in all the interviews. Participants talked most about **physical activity**. These activities took place in a variety of settings and were characterised by acts of 'doing' or 'making': e.g. football, playing on computer, drawing, skateboarding, cooking. They were often associated with individual interests and hobbies, and usually a way for participants to describe themselves ('I am someone who likes ...').

R: ... to do things and find things out, and go ... running through the woods, and making dens and things. (15, 7)¹⁰

Physical activity was associated with positive feelings (e.g. happy), and energy,

R: Jump around, singing and dancing, you know 'yehhh, yeehhhh'. When I'm happy, I make up little songs and things. (16,9)

I: Ok, great. So to be excited and to be jumpy, what, what does that mean?

R: It kind of means that, well, when I'm excited I feel as if I can't stop talking and I want to just rush out everywhere, blurt out everything that's ever happened in my life, ... I'm, full of energy ... I'm more likely to run around in small circles [and] can't stop talking (9.3-9.5)

R: Erm, like, having fun and enjoying yourself ... doing something like what you like. (19,1)

Physical activity was also used to enhance positive feelings (e.g. via distraction),

I: Why is it important to do things you enjoy?

R: So you, like, you can um, er, relax a bit more ... you can get um ... thoughts ... like ... get stuff out of your mind, that you're worried about.

I: How does that work, then?

¹⁰ This locates the quotation (transcript number 15, page 7); also R: respondent; I: Interviewer.

R: *Because it's like you're doing lots of stuff, and it's, like, making you think other things, and um ... it's like, kind of ... it's going out of your head.* (19,2)

and could be related to positive physical sensations,

R: *... my cheeks tend to automatically go into a smile [ok] and around my chest it feels just like it's about to burst out ... my top always feels like, 'when was the last time when did I buy this?' I'm looking at the label [shows researcher how jumper feels small] ... I'm really full of myself ... I don't know how to put it, suddenly someone's, tipped a whole lot of stuff down my throat so I've swelled up sort of ...* (9.5)

Participants also referred to **mental activity** – which involved thinking things through and concentrating,

R: *... um ... have you seen a programme called Crystal Challenge? ... I kind of like ... I spend, like, spend ages, in my head, thinking out how I'm going to do it.* (8.13)

as well as wondering and having hopes and expectations.

R: *I was thinking I wonder if its going to be like the book [going to Harry Potter film], I wonder if they're going to skip out any scenes, just wondering and wondering ...* (9.5)

R: *I'm hoping they really do like their presents ...* (11.6)

R: *I wish we were together again...* (21.6)

Overall, the theme of activity was linked to being engaged or involved with things,

R: *.. [in class] .. I wouldn't really pay attention. But now I know my [times] tables, ... I used to, like, be sat on the carpet, biting my fingers, because I didn't have a clue what was going on. But now, I can sit down and just keep watching.* (8.4)

This involvement, when rewarded with success, resulted in positive feelings, and a willingness to engage more and **have a go at things**.

R: *And, mm, I think, I think, actually doing stuff you wouldn't do normally, and you may be scared of it but then if you do it then it makes you feel really good inside .. and that makes me feel happy cause .. when you do things like that, ..* (16,2)

Participants talked about self-encouragement and reminding themselves of past successes,

R: *That's just like something inside you, and it's making you ... and you feel quite happy, and, like, you had worked really hard for something, and you find out that the work had paid off ...[and]... You normally feel like something's inside you, trying to ... like your conscience, saying, "Oh, come on, you've done something really well, you can do something again like this ... again and again, carry on working hard, and you'll get something else maybe".* (15,5)

with many recognising the connections between positive feelings, thinking and behaviour,

R: *Well, when you're happy, you feel like you wanna do things, you don't wanna just be bored and sit around and watch TV, you just wanna, like, run around ... and let some energy ... get rid of some energy.* (15,4)

R: *Cause if you wake up feeling happy, I'll try my hardest to stay feeling happy... Cause it's kind of nice when you wake up happy and then go to bed happy ... but if you wake up and you like 'I don't want to go to school today' ... then, then you don't really have a very good day, so you, you've got to look on the bright side of things.* (16,9)

During most interviews activity was also repeatedly contrasted with descriptions of **inactivity** (both physical and mental). Participants talked about being ill and feeling 'weak', having to be at home and being unable to join in activities.

R: *So, like, if you hurt your knee, or leg, you can't play football ..[and] .. You're thinking like you can't do anything ... mentally, you're not feeling a hundred per cent.* (7.1/6)

R: *Well, when you're ill you feel right down, glum, bored, just not very happy, 'cos you haven't got anyone there to play with or talk to ... you still want to go and do things, but you feel like staying in bed ...* (20.2/8)

R: *Like when I was ill a couple of weeks ago, I had to just sit around, I couldn't go to school and be with my friends and things, and I was feeling quite lonely and sad.* (15,2)

In general, inactivity was associated with negative thoughts and feelings (e.g. sadness, confusion, boredom), and characterised by participants choosing *not* to be involved,

R: *I often slouch down in my seat ... I actually go really quiet, because I'm quite talkative at school and at home, and I kind of go quite quiet ...* (8.10)

R: *Um, I ... normally go and sit in my room and put the radio on, and then I doze off, because I don't like to stay awake, because it just hurts inside. I like to sleep.* (11.12)

This was in contrast to the self-definition associated with activity described above,

R: *Er ... dunno. Feel quite vacant ... Yeah, like you're not really with yourself, you're just like ... there ... Just sitting there, mind not on anything ... It's just not doing anything.*

I: *Okay. So the next question might be pretty hard then, because ...if you were feeling like that, what was going through your mind?*

R: (LAUGHS) *That I was switched off.*

I: *Were you actually thinking you were switched off?*

R: *Er ... I wasn't thinking anything, because I was switched off!* (22,7)

Participants also described activity that required less physical and mental effort, but was still considered 'doing'. These were associated with **relaxation**.

R: *Just lying back, not rushing around all the time. Laying back for a little while.* (20.2)

I: *What about listening to music? .. Why is that important?*

R: *Er ... because ... um ... you can just sit there and listen, ... like, just chill out... 'cos you don't really do anything, you just sit there and listen.*

I: *Tell me what "chilled out" means.*

R: *You just feel ... oohhh! Quite comfortable with the way you are and that.* (22,11)

Participants reported these activities helped them feel 'okay' about themselves or more balanced.

b. Attitude to self

During the interviews, participants talked about how they felt about and perceived themselves (via activity but also more generally). Experiencing success, reaching goals or learning skills (e.g. doing well at school, saving up money, being skilful at a game), was often reported with enthusiasm and recognition of their achievement. These occasions were associated with positive feelings and confidence to try new things and take opportunities (as noted above). Again, in relation to the self, these experiences resulted in participants feeling more **certain of themselves**.

R: *If I've reached the sort of goals that I wanted to do, I'll say 'Yaaahey' and 'Wheee'* (22.6)

R: *you're doing okay in things ... you think you're doing well on a piece of work or something ..* (15.1)

Participants also discussed being accepting of themselves.

R: *Mmm, just being happy with who you are cause you can't change yourself [right] and so, if you are happy with who you are then it will make you happy inside... Because you're who you are and you're not going to be able to change that.* (16,2)

This was contrasted with situations where participants felt **less certain of themselves**,

R: *I've never really known what I'm like ..* (9.5)

R: *.. and I thought, I'm sure I'm not that good ..* (8.3)

R: *you feel quite sad, and like you don't want to do anything again* (15.4)

3.3.2. *Self in relation to others*

Participants talked about themselves and their well-being as individuals but also in relation to others – mostly family members and peers.

a. Being yourself

As well as being accepting of themselves (as noted above), retaining a sense of self when interacting with others was also considered important by many participants.

R: ... I'm being myself, I'm being ...

I: What does it mean to be yourself?

R: Um, it means that I'm not trying to be like somebody else, I'm trying to be my own personal self, and I'm not trying to, like, copy someone, or something like that. (6.2)

R: Because there's no point pretending, because it only hurts you, and you're like ... say people your own age, that they act grown up, and you try and act grown up, it's not you, and you just wanna go, "Oh no!" and it's like when you have little kids that follow teenagers and act all grown up, but when they get home, they play with their little Barbie dolls and stuff like that. I have a cousin that does that! (11.13)

Participants talked about expressing this with peers,

R: If you don't like someone doing something, say, "Could you please stop. I don't like it".

I: To tell them that you don't like it.

R: Stick up for yourself. (7.8)

But also often defined their own abilities in relation to peers,

R: [improving in maths] I felt really good 'cos I'm catching up with them .. (8.3)

b. Shared activity

While important to retain a sense of yourself, participants talked about the importance of relating to others, and in particular the importance of shared activities – usually ‘hanging out’ with friends,

R: Having a mess around with your friends, you know, laughing, giggling, joking, that sort of thing. (20,2)

or enjoying shared hobbies and outings with family.

R: like ... when something's good happened... like ... when your mum and dad, and Nan and Gramps has got like a surprise for you ... Like taking you to the beach, a present. (10,1)

R: Erm, well, there was just, like, well, me and my mum and my sister and my dad, and my little sister was ... was going out for something to eat, and it was very ... um ... we all felt close together, and that made me feel really good. (13,3)

c. Negotiating relationships

Activities and relationships with significant others clearly had an impact on participants' well-being. In the majority of interviews, **being involved** and feeling included by others led to positive feelings and thoughts,

R: Well, like ... um, you wanna play with people and ... you really want to, like, have everybody near you, so you can ... because, like, people make you happy sometimes ... by just saying something to you.

I: Okay. Tell me a bit more about people making you happy by just saying things to you.

R: Just like saying that you're a really nice person, you're their friend, that can make someone very happy. (15, 2)

However, relating to others required negotiation and understanding of how individuals should behave towards one another. Participants talked openly about (often implicit) **rules and expectations**.

R: *If you've got loads of friends you'll be a popular person and you'll get a better life ... Having more friends means its less likely that others won't like you.*

I: *What does it mean to have a better life?*

R: *Not being left out ... Erm, don't boast a lot, ... people will just hate you ... nobody likes someone who shows off or anything ... its just a horrible thing to do and it makes people feel upset, disappointed and if you make people feel like that, then well whose going to like someone who does that?* (9.11)

Efforts to 'fit in' could contradict ideas of 'being yourself' as described above.

Participants referred to an awareness of the consequences of *not* being involved,

R: *I'm just that sort of person who won't say nasty things ... Like ... if I did, they'd probably, like, start back at me and that, and they would probably try and have, like, a fight or something.* (10.7)

Fear of (or actual) exclusion was something participants associated with negative feelings and situations,

R: [after a practical joke went wrong] *Erm ... I felt really ... um ... sad, and ... people ... said ... "that was a really dangerous thing", and I said, "I'm really sorry". ... I sort of felt, really sad, and thought that people wouldn't like me any more ... I was going to be left out of games ... they weren't going to let me play ... so it kind of makes me an outsider ...* (6.6/8)

This was described as having an impact on individual well-being,

I: *What does that mean to be a tense person?*

R: *Mm, on the edge ... it means that every bit of respect that anyone's got for you in your life is hanging by a thread ... Like everyone's going to hate you if I do a certain thing.* (9.9)

In terms of negotiating relationships, participants mostly talked about peers, but some also discussed their relationships with siblings.

R: ... if it's like at home, my sister will be really mean and like, ... last time I got her really badly into trouble, mm, I was collecting Pokemon cards at the time I think and she, mm, goes into my room and rips a few up and mm, I was, I got really irritated then. (17.6)

As in this example, difficulties with peers and siblings often resulted in negative feelings - frustration, anger and being cross with others. Expressing these feelings was managed in different ways. One participant wrote 'angry' and 'sorry' letters (tearing up the former and dropping her apology ones down the stairs). Some talked about being aware of how these feelings could influence their behaviour,

R: .. you might get cross with yourself because you're upset, so you might pick a fight with somebody else .. (5.8)

R: go up to your room and [ok] and lie in bed ... 'cos you're feeling so annoyed and you might break toys or something ... But then you'll probably regret it after [ok] when you're back in a good mood. (18.7)

others tried not to express difficult feelings,

R: I don't, like I get annoyed inside but I don't really like saying things (16.10)

R: I keep it inside me, and ... I just, like, push it to the bottom of my heart, and just make it stay there ... I try and forget ... I try and think of something, and do something, before, ... But I try not to do something bad. (15.12)

while some described why it was important to 'let them out',

R: but you ... that you should cry, because it sometimes lets the steam go out.

I: What do you mean by "steam"? That's an interesting idea.

R: Um ... it means like all the thoughts going inside you, that you can't let go, because you're scared to.

I: And why is it good to get that stuff out?

R: Because otherwise they'll be going round in your mind, and you'll be holding, like, a grudge against people, and you'll be saying, "Oh, go away!" and stuff like that, to the other people. (11.9)

Despite difficulty involved in negotiating relationships, the majority of participants also talked about many positive aspects of relationships. Friends were often described as a **source of support**.¹¹

R: I can rely on my friends more than other people, because I know my friends better. (7.8)

R: .. if you're all alone, and you need someone to comfort you, friends are there for you. (13,3)

R: ... you always feel as if they're with you ... (20.10)

Friends could be trusted to share feelings with and participants reported sharing concerns and checking responses out with them,

R: Well ... probably to have friends and be able to tell people things, and ... um, well, being able to tell people things that are crazy, or if there's something worrying you, you can tell someone, and it usually makes it feel smaller, or ...

I: How do you mean, "smaller"?

R: Well, say it was really worrying you, and you told someone, it sometimes makes it feel like ... you find it stops you worrying ... so I suppose that makes it not as big. 12,2)

In general, being with others was something participants said they did *more* when things were going well,

R: I'm more likely to go out with my friends ... I'm more likely to let other people ... play with my things, ... share with people ... and might go speak with my friends if they're feeling down and, like, try to cheer them up. (6.5-6)

This **reciprocity** – thinking about and helping others – was regarded as another significant part of all relationships by participants,

R: Because, um, it's like they don't, your parents don't ask you for much. I mean, they feed you every day, they wash your clothes and stuff like that, so the least you can do is just

¹¹ Adults could also offer support but this will be presented within section 3.3.4.

give them a little help ... and say if your mum's doing the washing up, you can go to her and say, "Can I ... do you want me to help out?" .. (11.2)

R: Try and think happy things, to make them feel happy. (14.12)

This also often brought benefits and positive feedback for participants themselves,

R: Yeah, say if ... someone had hurt someone else, you go over and help the person who's hurt, and so then you feel really happy with yourself that you've helped another person. (6.10)

R: [after helping out]... you feel proud, that you've done something extremely well, and, like, everyone's quite proud of you and everything, (15,4)

When participants were not feeling great about things or themselves, they reported being less likely to be with, but particularly to help, others,

R: Yeah, 'cos, like, she'll say, "Can you come and help me with the dishes?" And I'll go, "I've got to go up and do my homework", to keep away from it, ... I won't, like, do my homework ... I want to be alone. (8.11)

3.3.3. Growing up

This reciprocity of relationships often related to participants' recognition of themselves as individuals with developing skills.

a. Increasing abilities

The process of growing up meant many participants were experiencing increased **independence and autonomy**,

R: Kind of like you're not always having to get your parents to do everything for you ... Well, you can ... well, like getting yourself changed, because I've got a little sister, but she still has to have my mum help her get changed, but then I can now get changed on my own,

get ready for school, my bag done, and my lunch box, and I can just go ... then I can wait for my friend to come and call for me, to walk down, and then I just go. (8.1)

which resulted in increased freedom and choices for individuals,

R: ... your family aren't asking you to do jobs every two minutes and you can have a bit of time with your friends, a bit of time on your own whenever you like basically. (9.2)

R: It's like, if we go into town, ... now I can go off and ... meet my mum back ... it's quite fun going off on my own, because I can go into the shops ... my mum won't, like, want to go into ... and spend as much time as I want (8.2)

R: Yeah, I was feeling quite proud ... because I've never been allowed to cook before ... by watching my mum, I've learnt how to cook, and I can do it. (15,6)

The process of growing up was also reflected in participants' awareness of **complexity**. This involved the ability to recognise their current understanding (comparing self with others: siblings, or younger self, e.g. explaining how at age 5 a participant hadn't understood when her grandma died). Many participants were also able to see things from (and empathise with) others' perspectives.

R: [referring to separated parents getting on okay] I was really happy because, like, usually, when we, um, with my mum and dad, we always ... like always have a fight, and then they storm off, and me and my mum have to go home and stuff like that. So I was really happy ... relieved (LAUGHS) ... a bit sad because, like, erm, we used to always be like that at old times, it made me look back and think about all those nice times. (21, 3)

This could mean grappling with mixed feelings, and at times appreciating their own **impact on others**,

R: Um ... I hate it when I'm really miserable, because it makes people around me get really grumpy, so it's like I'm the cause of all of it, and I don't like to be that. (11.4)

R: I felt a bit down, because I made my mum unhappy ... [and] .. A bit cross, for answering her back ... you just feel that you shouldn't have done it ... (16,8)

This could lead to participants experiencing difficult feelings (e.g. down, guilty) – which for some resulted in a sense of self-awareness;

R: Mmm, I feel a bit horrible ..[and].. I like started being really conscious that I just like, cause usually I'm not very conscious of my feet and my hands. I just do things automatically, so then I become a bit more conscious of my feet and hands. (17)

for others, a desire for distraction – or disappearance,

R: ... you don't want this to be happening ... Erm, my head starts screaming at me ... My conscience says things to me ... I'm naughty and bad, it just makes me feel awful ... I'd either hide my hands behind my back .. Kick myself under the table, Shut my eyes. (9.7/10)

Growing up presented opportunities (autonomy, choice) for participants – which could be self-enhancing. However, this brought a recognition of difficult feelings and complexity – which could relate to not feeling fully integrated (i.e. too focused on self, hiding, not wanting to be present).

3b. Sense of responsibility

With increased understanding and experience, many participants reported feeling responsibility, for themselves – both now

R: Just ... um ... like looking after yourself, because if you want to keep yourself safe, because, like, not ... don't go and do something really dangerous that, you know, because you've got to look after yourself, (8.1)

R: Erm.....erm....it's going to be Friday tomorrow, and I always try and get my homework done before Friday so that I can play loads on Friday. (18.4)

and for the future;

R: So you can get an education when you're older ... So that you won't be just sitting around trying to get a job, you'll have a good, decent job, and you can earn a lot of money ... Because if you don't earn a lot of money, you won't be able to pay the bills. (13.14)

R: Well, if you listen ... like when your teacher's telling you stuff, you'll get all the stuff right, and you'll be, when you're older, you'll be a really good listener to your friends. (13. 3)

as well as for others – both now,

R: [talking about supervising school lunchtime] Yeah. I don't like to be the one who has to be responsible, really, on my own, but I wouldn't mind being responsible if someone else was responsible for the same thing. (12,12)

and in the future – with one participant remembering how she had decided she wanted to be a doctor to find a cure for cancer, following experience of a family bereavement (number 4).

This sense of responsibility was apparent in participants' expression of worry and fear (about bad things happening to them or family),

R: Erm ... stay away from nasty men.

I: Ok. Why is that important?

R: Because you never know what they've got on them ... Like a knife, things like that. And ... don't go to places what aren't safe. (10, 13)

R: Yeah. I do think a lot about ... some of my family ... Because, like, my Gran, she's quite ill, and ... sometimes, in the night, if I hear a siren, I kind of like think, "I hope that's not going to my Gran" ... she falls, and I sometimes get scared. If I'm ringing her, say, I sometimes get worried that she's ... like, fallen down the stairs and really hurt herself, and she can't move or anything. (11)

c. Limitations and constraints

Some participants illustrated a tension in their descriptions - between their increased understanding and constraints brought about by their position, such as frustration at not being able to express themselves in the interview (own cognitive limitations).

R: Um ... I don't really know. Well, I feel as if I probably know, but I can't really ... don't really know what to say. (14.6)

Participants also described being reminded they were a child, by adults asserting their authority (e.g. many talked about not liking to be told what to do). Such situations could be seen as limiting choices,

R: We're not supposed to touch things .. (15.4)

R: Erm, well when you're ill I always feel like I'm being well, looked after a bit too much, I like to look after myself. (9.2)

and were associated with more negative feelings,

R: I had to stay in this break time for messing about the other day. That was another 'Doh!' feeling. (22.7)

R: Fed up, because I have to move quite often and I don't complain .. [about older sister revising for exams] (16.8)

3.3.4. The role of adults

In part three of the interview, participants were asked to give their advice to adults about how they could help children stay well. However, relationships with adults (parents and teachers usually) were also mentioned throughout the interview.

a. Being respected as individuals

Participants described wanting to be recognised as individuals, with thoughts and opinions of their own,

R: Yeh. I'd like to have a say in, a lot of things.. lots of things, not just like in, around school and things, I'd like to have a say in like things [right] around the world and stuff, but, and I tell my mum and dad, and they say, 'oh that's a good idea', and, no, nothing ever, no, nobody would ever listen to you, even if you like could write to . anybody in the

member of parliament or anybody in the police you know, but they just think, you know 'that's a kid', you know, they're not going to listen to you, (so) ... when it's small things, people do listen, like at school or at home, but big things, you know, you want to say things though, but they don't let you (laughs). (16,10)

and for adults to appreciate their need for information and to be involved in decision-making,

R: Erm ... "I really wanna tell them" ... Or say, "I really want them to tell me"... why they didn't go ... That they've, like, gotta tell you.

I: Why have they got to tell you?

R: Then you know why they didn't take you [on a family trip] and that ... I would, like, ask, or say, like, "Take me somewhere else, it ain't that far away", and that ... Um um ... that you wanna, like, get, like, the truth out of them.

I: Okay. So getting the truth. Why is it important to have the truth?

R: So you really know what's happened. (10.10)

Others felt adults should be more aware of the impact of their own behaviour on children,

R: Um ... if you're, like, having a fight with your wife or husband, you could ... if you could try to sort it out a different way, that will make your children feel more comfortable. (13,15)

R: Don't go on and on and on at them ... give them a tiny little telling off you know like ... but leave it at that, don't go on for quarter of an hour.

I: Ok and why not? Why shouldn't they go on?

R: They just feel worse and worse and worse, and if you go on for any longer it wrecks their whole day. (9.12)

The importance of being acknowledged by adults was demonstrated when several participants explained how nervous they had been before the interview. Many described breathing a sigh of relief when they were introduced to the researcher – as they had been called out of class without anyone explaining why or reminding them of the study.

However, while participants suggested advice for adults in relation to children's well-being, they also talked about positive aspects of relationships.

b. Recognition and support

Adults provided encouragement that heightened participants' sense of self,

R: *Um ... because Mrs. B (teacher) said if we did quite well in our tables, [she] lets us read out the answers and she said, "soon you'll be reading it", so it made me feel quite good, I kind of like thought, "Oh yes!" ... So it was like I was really pleased with myself.* (8.2)

R: *Erm ...the manager came over and said to me, "Good game, and then I felt, "Oh, okay then ... I feel really happy" ... like your heart starts to feel happy, you start to smile and things, and ... like, move your arms, like, say, "Yes!". ... um because you like to show your stomach ... it makes me feel sort of like, "Oh, good, I'm important" ...* (9.3-5)

R: *Or when something, when someone's told you that you've done something really well, you feel happy.* (15,10)

Participants further wanted adults to offer more positive recognition,

R: *Um, people should, praise you for some ... not for the bad things, for the good things, like say if you do a really good drawing, or you write a very nice note to somebody ...*(11.2)

R: *Like try to talk to people instead of, like, shouting at them.* (14,12)

but also talked about adults' role in helping children to learn skills – both practically and socially,

R: *They [teachers] should ... um ... the teacher should help the children with, like, maths, literacy, and their skills and friendship, and things like that.* (6.10)

Finally, many described the significant role of emotional support from adults,

I: *What would your tip be for adults, how they can help children to keep well?*

R: *Say, like, if they look unhappy, they probably feel unhappy, so you could go and comfort them.* (7.9)

R: *If their child was getting um, a bit stressy, they should say, "What's wrong? Because you've been like a bit rude and stuff. Is anybody bullying you?" And talk to them about it.* (21,13)

R: *I talk to my dad and my mum because they listen lots [right].. and then, stuff.* (16.10)

and how this contributed to individual well-being,

I: *And does that help?*

R: *Yeah, it does. And I wake up and run and give my mummy a cuddle.* (11.12)

R: *So that you know someone loves you ... Because when you're older then you'll know that, that you was born into a family that cares for you ...* (13.14)

R: *I feel loved because my mum takes time off work to come and look after me when I'm ill ... when I'm loved and safe, I just feel like really cosy, sort of warm inside ...* (20.8/9)

The over-arching theme of self-definition is present in relationships with adults – who despite presenting limitations and constraints, were described as supporting and reinforcing a sense of 'self' and individual well-being.

Many tensions were also expressed throughout the interviews, and participants often described the importance of achieving some kind of 'balance' between these. This was described in terms of autonomy 'v' support. One participant talked about feeling independent and having choices when he went into town with friends. However, his friend's father was nearby if needed, and when he ran out of time making up his mind to buy something, his dad took him back to the shop the following day. Another participant reminded adults it was important not to shout too much, but not to be 'really kind' either, '*otherwise people will take advantage of that*' (participant 20). Balance was also important for individual feelings (e.g. balancing physical activity 'v' relaxation), and overall ideas about well-being - having enough money to be okay, but not being '*too rich so that you don't enjoy treats*' (participant 5).

DISCUSSION

4. DISCUSSION

4.1. SUMMARY OF FINDINGS

This exploratory study was interested in understanding children's descriptions of well-being and what it means to be well, using a qualitative approach. Children participating in the study were able to provide descriptions of well-being and to consider associated thoughts and feelings. These covered physical, emotional and social aspects of well-being, and a recognition of individual development. Using IPA (Smith, 1996; Smith *et al.*, 1999), four main themes were developed: 'self', 'self in relation to others', 'growing up', and 'the role of adults' – relating to an over-arching theme of 'self-definition'. Positive feelings, thoughts and situations associated with being well were characterised by acknowledgement and expression of individuality. Negative feelings and reduced opportunities for self-expression or affirmation were associated with things not going so well.

This section will consider the research process and methodology used in the current study. Themes will be discussed in terms of the original research questions and relevant literature, with clinical implications considered. Reflections on findings of this study will be given, followed by conclusions and suggestions for future research.

4.2. REFLECTIONS ON STUDY

Reflections throughout the research process were recorded in a research diary, used to check ongoing ideas and assumptions (*Appendix 15*). Reflections on strengths and limitations of the research process and methodology are discussed below:

4.2.1. *Data Collection*

a. Schools

The researcher experienced positive support from Head teachers and schools. On reflection, important factors were: being flexible; providing clear details of the study; recognising they were busy and allowing time. In addition to this, only a small number of participants were required from each school. This increased the researcher's work, but for schools the request seemed manageable. It also provided a wider sample of children from different backgrounds.

b. Children

This study was exploratory and used a small sample with a narrow age range. Within this, more than half were willing to take part in interviews (response rate: 60%, higher from (smaller) village schools and females). As Parker (1984) suggested, it is relatively unusual for children to experience sustained attention from adults, keen to understand what *they think* about an issue. Using this format provided rich data. This was supported by the use of clear, developmentally appropriate details about the study and interview schedule. The interviews, although semi-structured, were conversational in style, and visual prompts encouraged further responses.

The interviews further took place within a familiar environment. Any research setting inevitably influences responses, but participants were generally relaxed and talked about a range of situations (i.e. at school, home, outside). Participants at times chose *not* to talk about situations, while others re-checked confidentiality (e.g. 'will anyone else hear this tape?') before discussing experiences (e.g. bereavement). Such participants reported it was helpful to talk. The researcher was challenged by how a researcher or clinician might respond differently to disclosures.

Overall, participants engaged in the process and contributed many ideas, with an enthusiasm that was contagious. There was often humour during interviews and all reported being pleased they took part, with many stating the interview was more interesting than expected (and better than being in class!). The researcher enjoyed conducting the interviews, often surprised at the trust shown by participants (i.e. for this one-off meeting for only 45-60 minutes). The striking feature of the interviews was how strongly each individual's personality was conveyed in such a short time.

4.2.2. Methodology

This study used a small sample with a narrow age range. The method was selected not for generalisability of findings but to provide a rich picture to inform further work. One-to-one interviews led to a focus on conversations that occurred ('it just felt like any normal person asking questions', *participant 5*). Parker (1984) referred to the importance of this relationship between interviewer and child, which holds both 'problems and promise' (e.g. knowing when to adapt the interview for individuals without biasing data). Overall, the interview schedule allowed flexibility to

respond to participants within a structure. A qualitative approach was appropriate for this study and the researcher's own preference for understanding the 'meaning' of what participants had to say (rather than how many said what).

The transcription and checking of interviews was time-consuming, and on reflection a smaller sample would have led to a more thorough analysis of each transcript. Smith *et al*'s (1999) description of IPA provided a clear method, with sequential steps of analysis and a useful framework for immersion in the data and the development of themes. In practice, it was difficult to work with one transcript at a time (links would be made with examples from other transcripts, requiring constant checking). While aware this was inherent in the method, the process of immersion also brought a recognition of the 'subjectivity' of themes (i.e. representing *one* researcher's interpretation of the data). The researcher used supervisory relationships and a colleague to 'check' the validity of work across this study. As IPA explicitly recognises researcher bias and assumptions, a research diary was also invaluable in tracking ideas and original questions over time. However, this study is limited by one researcher working alone and a team of researchers working together may have more opportunities to ensure robust theme development.

The main themes were presented in section 3, with definitions of well-being, and thoughts and feelings (sections 3.1 and 3.2). These naturally forming categories were presented separately due to word limitations. Overall, the issue of space and word limits felt constraining for a qualitative study. The researcher found it frustrating to balance both presenting the study and findings clearly, while also conveying the complexity of the analysis and development of themes. Some useful information further had to be left out or cut down (e.g. it was only possible to give excerpts from the research diary and an interview transcript). While an effort was made to leave an 'audit trail', it was difficult to give a full account of how initial categories in the data were identified and some collapsed during analysis to create final themes. On reflection, the researcher could have attempted to present within the text some of the difficulties faced when developing themes from the ideas emerging from the data (e.g. using example questions and dilemmas that were cut from the research diary and placing these as 'memos' within the results for the reader to follow).

4.3. INTERPRETATION OF THEMES AND CLINICAL IMPLICATIONS

While this study was exploratory and used a small sample, the themes generated reflect many issues raised in related literature. The themes will be discussed in terms of the original research questions (section 1.6.1.), with potential clinical implications also considered.

4.3.1. *Can children describe what well-being means to them?*

a. Discussing complex ideas

Bowling & Windsor (2001) suggested that thinking about areas such as well-being requires individuals to consider and evaluate their life (past, present & future) and values. This is difficult, requiring effort and cognitive skill – which may have contributed to the relative lack of research in this area. Using a qualitative approach for this study gave participants time to think about this complex area. Participants often acknowledged some parts of the interview were more difficult but also enjoyed the experience and benefited from encouragement to think about their ideas (e.g. ‘it’s learnt me a lot ... like, to keep safe, what to do ... how to enjoy yourself’, participant 10). In a familiar setting, with developmentally appropriate language, and encouragement to elaborate on responses (e.g. ‘tell me a bit more about...?’), participants *were able to* discuss well-being. As Kalnins *et al* (1998) report, the belief that areas such as mental health are too abstract for children to discuss is not borne out by asking them - provided discussions are grounded in the context of children’s daily lives. Asking participants to choose examples of ‘well’ and ‘not so well’ situations seemed to provide a useful framework for accessing children’s ideas, thoughts and feelings.

b. Developmental issues

As a specific age range was used in this study, it was important to consider findings in relation to developmental ability, and acknowledge that other age groups may differ in their response to similar questions (Jutras *et al.*, 1997). Participants were pre-adolescents (also referred to as late childhood). Using a Piagetian model, this

falls within the concrete operational period, where children can now appreciate others' views. During this time they are learning: to regulate emotions (by changing situation but also thoughts); awareness of rules and emotional ambivalence (i.e. mixed feelings); and recognition of how actions can lead to disapproval (i.e. their own impact on others), (Carr, 1999). These developmental issues were present in the data, particularly in 'relating to others' and 'growing up' (see 3a(ii), understanding complexity).

Using Erikson's (1959) psychosocial stage model, late childhood focuses on 'industry v inferiority' and the recognition (or not) of using individual skills to achieve goals. These skills are rewarded by school, family, and peers - leading to a sense of competence and self-efficacy (Carr, 1999). Again, these tensions are present in the data. Participants' recognition of their skills (in theme 1), and confirmation of these by others - peers (2c-iv) and significant adults (4b) - were present throughout the interviews. This age group is also moving toward developmental tasks relating to adolescence - peer group identity (belonging while retaining a sense of individuality, Carr, 1999). This dilemma was present when participants' discussed the importance of 'being yourself' (2a) but also 'fitting in' with peers ('being involved', 2c-i). When young people do not 'fit in', they experience isolation and have difficulty developing the social support networks that are important for health and well-being (Carr, 1999). Again, this was highlighted when participants talked about the fear of being 'left out' (2c-ii), and also relates to dilemmas for adults providing opportunities for independence (3a-i). The importance of striking a balance between over permissiveness and avoiding over-restriction was referred to by a number of participants.

Clinical implications

As Cowen (1994) noted '(psychological wellness) is not a term that defines itself easily' (pg.151-2). There is also a general lack of understanding about how children conceptualise well-being and mental health within the normal population, to balance models developed from clinical samples. The developmental model can be used to contextualise children's concerns and thoughts about issues. It is also important to recognise that with appropriate support and encouragement, children can discuss

complex, abstract ideas. Efforts to define such ideas can be contextualised in terms of children's daily lives, where specific examples can provide an opportunity to help children talk about their feelings, beliefs and attitudes (Jutras *et al.*, 1997; Kalnins *et al.*, 1998).

With a lack of information about what well-being is, it becomes important to gather a range of views from both clinical and non-clinical samples to provide a balance with the 'disorder-orientated focus' within mental health (Shatte *et al.*, 2000). A broader perspective provides material for use in population-based approaches within mainstream services (e.g. schools, primary care). Better understanding how children conceptualise and use terms further enables programmes to target specific areas of concern for children and young people, in a way that is relevant to them and their daily lives (Jutras *et al.*, 1997), and paying attention to contexts in which children live (Morrow, 2001).

4.3.2. *Are children's definitions of well-being more than 'an absence of illness'?*

As discussed in section 1, a 'deficit' model of health has focused on the 'absence' of disease and distress. This study was interested in whether such a definition was present in the interviews or whether participants conceptualised well-being in a more holistic way.

a. Definitions of well-being

Throughout the interviews, most participants *did* use 'not being ill' to define 'well-being'. However, there were as many references to 'being happy' – often described as being well in yourself, being with others and enjoying activities. Furthermore, when asked to elaborate on responses of 'not being ill', participants reported not only the absence of illness-symptoms (e.g. 'lying down', 'feeling sick', 'spewing') but more often the loss of normal activity (e.g. 'not being able to go to school', 'not being able to play'). When well-being was described as 'not being ill' therefore, this involved *the presence of positive elements and not simply the absence of symptoms or 'ill-being'*. As one participant said, after being ill: 'you'll be able to do what you normally do'

(15). This is an important distinction (Clark & Watson, 1991; Huppert & Whittington, in press).

Physical well-being was clearly important in participants' definitions of being well (presented in section 3.1). However, all three components of the WHO (1948) definition of health were described as important. Participants reported expressing positive mood and feelings; an ability to cope with stress (using relaxation, distraction); exercising mental and physical abilities (being engaged and involved in activity and play, practising and developing skills, recognising success and looking to the future); relating to others (negotiating relationships, giving and receiving support, experiencing love, trust and comfort), (Jutras *et al.*, 1998; MHF, 2002). These further reflect the developmental tasks discussed above and provide a broader, more complex definition of well-being and mental health than simply the absence of ill-being.

b. Comparing these with other studies

It is not possible to consider themes from this study in terms of all the conceptualisations of well-being presented in section 1. Although a pre-existing formulation could have been used to code themes in this study, the researcher chose to develop themes directly from the data due to a lack of published work relating to children's understanding of well-being in the UK. Ryff's (1989) six dimensions of psychological well-being, although developed from theory have only been used with adults, and mostly in the US.¹² Jutras *et al.* (1998) developed seven dimensions of mental health from interviews with a large sample of Canadian children.¹³

Many of the themes generated from the interviews in the current study overlap with the dimensions described by Ryff (1989) and Jutras *et al.* (1998). All reflect the importance of how individual's perceive themselves (e.g. high morale, self-acceptance, autonomy, compared with themes of certain of self, growing up); relationships with others (e.g. social support, positive relations with others,

¹² Autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, self-acceptance.

¹³ Social support, harmonious interpersonal relationships, expressing positive emotion, school involvement, high morale, relaxation, non-specific mental health.

compared with themes of support and encouragement, being involved, shared activities); and specific behaviours and activities (e.g. relaxation, school involvement, purpose in life, compared with physical and mental activity, relaxation).

Participants' understanding of well-being and things going well were characterised by positive involvement in activity; developing skills and understanding; feeling positive about themselves and others. However, these were further related to self-definition in that these experiences enhanced their own sense of themselves and who they were, (and this was demonstrated to others within a supportive social network). In contrast, 'ill-being' was associated with inactivity or a lack of positive activity/involvement, worries and constraints. These resulted in a lack of or reduced opportunities for both self-definition (e.g. 'not being in any kind of mood') and participation in self-affirming activity. The other conceptualisations do not highlight self-definition or tensions between themes - as expressed by participants in interviews (e.g. being yourself 'v' being involved with peers; support 'v' independence). In support of the work of Jutras *et al.* (1998), 'children's concepts of mental health are more complex than previous studies have suggested' (pg.31).

Clinical implications

a. Conceptualising well-being

Jutras *et al.* (1998) noted the literature over the last 30 years regarding children's health cognitions 'conveys an implicit definition of health as a physical matter' (pg.22). It was clear from participants' focus on social, emotional *and* physical aspects of well-being, that tapping one dimension only (i.e. physical) severely limits the amount of information individuals are able to provide about themselves. Morrow (1999) also noted that health promotion has tended to focus on physical aspects, with less attention on mental health, and social and emotional aspects of well-being. Linking the two would reinforce that we are all physical and mental beings (with physical and emotional needs), possibly reducing the stigma associated with mental health problems (Mental Health Foundation, 2002).

Participants also described well-being in terms of how individuals feel about themselves, with relationships and activities contributing to this. This supports the importance of considering individual, subjective views of what well-being is and also relates to the development of identity and self-esteem in children (Harter, 1983). Although self-esteem measures are often correlated with subjective well-being (Deiner, 1999; Huebner & Gilman, 2002), the current study focused specifically on well-being (rather than self-esteem). However, it is important to acknowledge the overlap between these areas. Examples of the components that have been described as contributing to self-esteem - self-knowledge, self evaluation, and self-regulation - are present throughout the interviews (Blaskovich & Tomaka, 1991).

b. Incorporating the positive

Huppert and Whittington (in press) recognise 'the difference between the absence of good feelings and the presence of psychological symptoms, is far from trivial' and this was borne out by participants' descriptions of well-being in the current study. As discussed in section 1, measures focusing only on 'ill-being' are missing potentially useful information about functioning. Children in the current study talked about well-being as related to positive feelings, thoughts and beliefs - increased involvement in activities and relationships. These positive conceptualisations can be used to develop measures (or balance existing ones) or to target interventions in a range of settings that make sense to children and relate to their daily experiences (Kalnins *et al.*, 1998).

One example is the role of schools in promoting children's development and mental health that has been increasingly recognised (Rutter, 1987; Mayall, 1996; Weare, 2000; St Leger, 1999). Negative school experiences are related to negative health behaviours, but less is known about *how* positive school environments foster positive behaviours or the development of autonomy and decision-making (Morrow, 2001). Buchanan and Katz (1999) reported 'young people who had a good experience at school, regardless of whether they were high achievers, were more likely to belong to the 'can-do' group' (those with high self-esteem). However, positive opportunities to develop emotional and social skills (e.g. circle time activities), compete with a requirement to prioritise practical skills (e.g. literacy) in an

environment increasingly focused on testing (Morrow, 1999). As noted by Huebner and Gilman (2002), a more emphasis on the teaching of emotional skills (e.g. conflict resolution, co-operation) is needed for all children, not just those 'at risk' – what has been referred to as an 'inoculation for life' (Goleman, 1996). Schools that have prioritised such an approach report an increase in pupil well-being, higher academic achievement, and lower rates of bullying and health risk behaviours (St Leger, 1999). The Bright Futures report (1999) recently suggested the use of 'holistic' school league tables and primary schools having a mental health co-ordinator to improve liaison between schools and primary care services.

4.3.3. How do children describe feelings & beliefs associated with things going well?

When grounded in situations relating to their own experience, participants were able to generate physical sensations, feelings, thoughts and beliefs. Some participants found it more difficult to think about their thoughts but could do so with encouragement, visual prompts and a few benefited from cartoon drawings. Participants also demonstrated a clear understanding of positive and negative cycles of feelings, thoughts and behaviour.

In terms of participants' beliefs about themselves – these were related to the self: characteristics (e.g. 'I am a happy person') and awareness of their own strengths and limitations (e.g. 'I can learn to do things', 'I am good at games', 'I'm a worrier'); and the self in relation to others: characteristics (e.g. 'I am kind', 'I am helpful') and what participants hoped for or needed from others (e.g. 'I need others to tell me I'm doing ok'). This reinforces the importance of the social and reciprocal nature of relationships participants described throughout the interviews. As with feelings and physical sensations, there was some cross-over between the situations – so that positive thoughts and feelings were not confined to positive situations. Discussing negative situations often resulted in participants generating many positive self-statements (as well as some negative – e.g. 'I can be mean and selfish'). Participants may be more reluctant to reveal negative aspects of themselves, although this did not appear to be the case in interviews. However, it also demonstrated how a non-clinical sample use positive *and* negative experiences to build self-identity, which was reflected in beliefs about self. It is also worth noting that participants' 'negative'

situations were often resolved by the end of the 'story'. Despite negative feelings and experiences (as well as outcomes: e.g. punishment, bereavement), participants' descriptions were characterised by a sense of how individuals managed situations. This may represent a difference between non-clinical and clinical samples.

Clinical Implications

There is a lack of information about the role of positive thoughts and beliefs in both clinical and non-clinical samples of children. Again, clinical psychology has 'emphasised the remediation of negative characteristics over and above promotion of the positive' (Schatte *et al.*, 2000, pg. 216). This is reflected in clinical studies and interventions. Kendall (2000) has written that therapy works by *reducing negative thinking* in treatment with children who have established disorders. Rather than replacing negative with positive-only thinking, therapy aims to change positive: negative thought ratios from 1:1 (e.g. in depression) to 2:1 (reported ratio of adaptive thinking in adolescents). However, this reduction in negative thinking is achieved via a focus on negative thoughts and beliefs.

Lightsey (1994) suggested increasing positive automatic thoughts in therapy may increase feelings of happiness and social worth, and tracking these over the course of recovery would be useful – as well as understanding their relationship to positive affect, self-efficacy and optimism. Padesky (1994) also refers to individuals with difficulties lacking adaptive schemas to balance maladaptive ones, and discusses the importance of building positive schemas. Fava and colleagues (1998) demonstrated the efficacy of focusing on positive well-being and positive spirals of feelings, thoughts and behaviour (e.g. keeping *positive* thought records) when compared with traditional CBT approaches for re-current anxiety and depression in adults.

In terms of working with children, those as young as six have been reported able to use cognitive-behavioural techniques (Kendall, 1995; Carr, 1999), but there remains little work looking at the role of positive cognition in children's everyday use or in therapeutic interventions. This could increase understanding of children's thinking and result in a more balanced cognitive model (as Fredrickson (2000) is attempting to provide a model of positive affect). Negative cognition has been demonstrated to be a powerful predictor of affect and behaviour, and it is not yet known whether positive cognition has the same

influence and how this could be enhanced. If negative thoughts exacerbate stress, could positive or self-enhancing ones buffer against it or help build resilience? (Lightsey, 1994). As noted by Gilman and Huebner (2002), having an optimistic disposition can be self-reinforcing, as individuals 'continually seek opportunities that potentially lead to positive interactions and outcomes, thus contributing to their overall positive outlook on life' (pg.17). This also relates to work on positive protective factors that can facilitate adjustment when faced with difficulties or improve outcome in interventions (Carr, 1999)

Developing measures that tap these aspects can focus attention on them. As noted above, there are overlaps with self-esteem, where measures do use positive self-statements (e.g. 'I am good looking', 'I have many friends', items from Piers-Harris Self-Concept Scale, 1984), and may represent a broader picture of individuals than symptom-focused anxiety and depression measures do. They could also be useful in developing individual treatment goals and evaluating outcomes (based on the self-definition aspect of participants' responses, where activities or relationships are important for 'what they say about me'). This is not to suggest (as noted in section 1) that a focus on the positive does not already occur in therapeutic work with children – just that it is often not *explicit*.

McCulloch and colleagues (2000) also suggest the need to 'pinpoint specific skills, beliefs and experiences that promote positive subjective well-being' in order to develop better prevention and intervention programs. Understanding which beliefs are associated with doing well and how can they be enhanced (e.g. via activity, achievement, relating to others, reciprocity) could be used further in programmes that aim to develop skills and build strength (as in the positive psychology literature). One example is the work of Snyder and colleagues (1997), who conceptualise hope as a journey (e.g. needing destination (goal), map (plan), and means of transport (skills to reach goal)). This is understood as a cognitive process (occurring 'first and foremost in our minds', pg.3), but different to one focusing on hopelessness (where knowledge concerns negative attribution and expectations). Programmes that aim to build strength in children can use these conceptualisations to develop skills (Schatte *et al.*, 2000; MHF, 1999). As Seligman (2001) has noted, interventions aiming to prevent difficulty require more than simply using established approaches earlier.

4.3.4. *What do children say helps them to stay well?*

Participants were specifically asked about what helps them and others to stay well in the final part of the interview. However, these ideas ran throughout the data.

Well in myself

In discussing definitions of well-being and situations that went well, taking part and being involved in activity (mostly physical, but also mental) was related to positive feelings and encouraged individuals to do more of the same. The importance of taking part in physical activity has been described as important by children elsewhere (Kalnins *et al.*, 1998; Bright Futures, 1999). Huebner and Gilman (2002) reported school satisfaction is associated with opportunities to participate in extra curricular activities. Being able to 'engage in play and recreational activities' is recognised by the UN Convention on the rights of the child (Prilleltienky, 1994). Participants also referred to the importance of activities that restored a sense of balance and involved relaxation (e.g. 'chilling out listening to music'), (as in Jutras *et al.*, 1998). In terms of specific activities and interests, but also in relation to 'growing up', participants talked about their own increasing development and skill acquisition (Armstrong *et al.*, 1998). This led to increased confidence and willingness to try new things. Increasing autonomy (and opportunities for this) brought participants choice and independence they associated with well-being. Again, these ideas were brought together in the overall theme of self-definition, which fits with the Bright Futures report's (MHF, 1999) recognition that emotional well-being is not just 'how are you?' but 'how are you in yourself?'

Well in relation to others

Morrow (1999) referred to social well-being as those resources derived from social ties. Participants in the current study often included others in their descriptions of staying well and talked about the importance of shared activities. Good relationships were characterised by trust, encouragement and support, as well as their reciprocity. Rigby (2000) reported perceived social support was a significant contributing factor in children's well-being. The importance of friends, family, and

informal networks as sources of well-being and support have also been reported elsewhere (Morrow, 2001; Mental Health Foundation, 1999; Turner, 1999; Huebner & Gilman, 2002).

Friendship (people you can trust and check things out with), and being involved and included by peers was important and enhanced participants' sense of themselves. Self-definition could be promoted, but also reduced by peer interaction (if left out, worry about negotiating friendships). In adolescents' reports McCulloch and colleagues (2000) found 'positive daily life events' made a unique contribution to life satisfaction, over and above major life events. The cumulative effect of everyday experience – positive, but also negative – has a significant impact on how individuals feel about their life. In participants' descriptions, being well led to further engagement with others and activities, contrasted with lower well-being (and less willingness to join in or be active, often characterised by withdrawal). Having others involve you, but also feeling positive and wanting to join in more could 'buffer' individuals against the effects of more difficult feelings and situations (Deiner, 1999; Huebner & Gilman, 2002).

Adults also made significant contributions to participants' well being (both teachers and parents). They were reported to provide emotional support – love, recognition and encouragement – but also help with skills (both practical, e.g. homework, but also social, e.g. about friendships). Participants talked about wanting adults in their lives to provide more positive reinforcement when they do things well (and less negative feedback when they do not), and to acknowledge their individuality (e.g. opinion and role in decision-making). Again, this reflects the UN Convention's emphasis on a child's 'right to express views freely in all matters affecting [them]', (Prilleltensky, 1994).

Achieving a balance

Consistent throughout participants' reports was the importance of attaining a balance between tensions they expressed. Physical activity was often described as balanced by relaxing or 'chilling out'; feeling a sense of autonomy was balanced with the importance of adult support and protection; receiving support from others was often balanced by helping and sharing in return.

Clinical implications

The Mental Health Foundation website (2002) provides a list of things to 'help ourselves' and our own mental health. They suggest: taking time to do things we enjoy, physical exercise, cut down on things bad for us, remember and celebrate things we like about ourselves, keep things in perspective, develop and sustain friendships, listen to and respect others, ask for help if we need it or distressed, support others but care for ourselves as well. Most of these were mentioned by participants as important to help them stay well. In this and other studies (Jutras *et al.*, 1998; Turner, 1999; MHF, 1999), children seem to have a good idea of what helps them stay well and can appreciate the complex links between self and others, being yourself and fitting in, growing up and being supported. While children are more likely to be asked for their views on issues that affect them, it is not clear whether these are actually incorporated into interventions targeted at them.

Jutras *et al* (1997) noted that most health promotion tends to focus on a single health behaviour, and this may fail to capitalise on using children's existing skills. One example would be using the reciprocity participants talked about in the current study. When involved in helping others, participants felt good about themselves, and when feeling positive they were also more likely to share or help others. During the interviews some participants explicitly mentioned how thinking others might benefit from the study had influenced their decision to take part. Using children's mutual help skills (Jutras *et al.*, 1997) could reinforce the healthy actions they already take and build on this to encourage children to share information with and support one another (with adults, friends, or peers with particular difficulties). Research on social support has tended to focus on receiving help and support from others, neglecting the benefits of the 'helper' role (Jutras *et al.*, 1998; Turner, 1999).

Peer-support interventions have been associated with an increase in self-efficacy and self-esteem in adolescents (for both helper and helped, Turner, 1999), which in turn influence health-related behaviour – and therefore access to health services when needed (Rutter, 1997). These programmes aim to provide children and young people with skills (e.g. listening, leadership) in a format that is less stigmatising, promotes the importance of talking things through, and enables them to experience

the satisfaction of helping others (Cowie, 1999). Young people can experience a range of difficult feelings and the effectiveness of strategies they have will vary considerably (MHF, 1999; also in current study). Understanding such feelings are normal and learning to express these are important skills for later life. Providing these in mainstream child services is in line with Cowen's (1994) focus on the 'enhancement of wellness', before the point where problems arise.

This is in contrast with specialist child services, where there may be a wait before accessing the service; it is often not the child's choice to attend (Kendall, 2000); and the child may see themselves as a 'problem' (Turner, 1999). In terms of the trust, respect and independence participants associated with well-being, specialist services can face a challenge from the start. However, 'psychologists [can] ensure that information related to positive events, as well as negative events, is collected as part of the developmental history and background' (McCulloch *et al.*, 2000, pg.288). Closer working between children's services may also lead to improved links between services, and the opportunity to contribute to the development of programmes in mainstream settings. The Audit Commission's 'Children in Mind' (1999) report found professionals working in CAMHS spent only 1% of their time liaising with other agencies and 25% of CAMHS had no real link with primary care (GPs). Clinical psychology is in a strong position to understand and share children's perspectives with those involved with children and working with them across a range of settings. Such information can be used in and contribute to interventions that support the building and developing of strengths, skills and abilities within families and community settings, within education and primary care (Appleton & Hammond-Rowley, 2000). Interventions at this level would further aim to enable children and adolescents to take increased responsibility for their own health and well-being (Cowen, 1994).

4.4. REFLECTIONS ON FINDINGS FOR CLINICAL PRACTICE

One of the reasons the researcher conducted this study was in response to the inevitable focus on 'dys'function in clinical training. In an effort to balance this, interviews in this study were conducted with twenty children from five local schools. From this research experience, the researcher will take away:

- The enjoyable experience of meeting twenty children who honestly and openly expressed their thoughts about well-being, and provided an understanding of the concerns of that age group
- The importance and complexity of self-definition that participants expressed – where the whole (self) is greater than the sum of the parts (friends, activities, independence, etc) - and the potential value of asking clients what well-being means to them, as a way of defining positive, individual treatment goals
- The discrepancy between telling parents they will get more of what they pay attention to (focusing *them* on the positive), and then asking clients to record their negative thoughts and complete symptom-focused measures (which are depressing even to read!)
- The reciprocity described by children in this study – and how a 'helper' role might be adapted and used creatively in clinical work
- The realisation of how much relevant literature and ideas relating to working with children gets lost between service boundaries (education, social policy, psychology)
- The hope that despite waiting lists, enough time can be spent liaising with other services and building links to support the promotion of health and well-being
- The practical impact of a child's social context (e.g. if play is fun but also provides opportunities for new experiences, taking risks, thinking through decisions, learning new skills & increasing self-confidence-what are the implications of living somewhere with little public space, where you and your parents worry about your safety when playing outside?)

4.5. CONCLUSIONS AND SUGGESTIONS FOR FUTURE RESEARCH

The aim of this study has been to consider children's understanding of well-being, and associated feelings, thoughts and beliefs. Participants provided rich descriptions that incorporated emotional, social and physical elements of well-being. Four super-ordinate themes were drawn from the interview data: 'self', 'self in relation to others', 'growing up', and 'the role of adults'. The over-arching theme of self-definition was present throughout the transcripts.

The area of well-being is complex due to the use of many overlapping terms and a lack of clear definition. There has been little attempt to understand how children conceptualise well-being, despite recent Government focus on promoting mental health and children's development (DoH, 2001a). The current study demonstrated that children in this small sample were able to talk about well-being, articulate their feelings and beliefs about this area; and describe what helps them to stay well. Participants provided multi-dimensional definitions of mental health and well-being, that overlapped with holistic definitions of health, other work in this area (Ryff, 1989; Jutras *et al.*, 1998), and work on self-esteem and self-concept.

Understanding what helps children stay well can provide useful information about factors contributing to well-being and mental health. This could be useful information for mainstream settings such as schools, with 'at risk' groups and in specialist services. This would also provide a balance with existing knowledge, developed from the deficit model and focused on ill-being. From a position of building strengths rather than repairing weakness, this also has implications for how goals of treatment are defined (i.e. what are we aiming for?).

Future research could usefully focus on other age groups to explore differences in children's responses in relation to developmental stages, particularly on younger children. The development and role of positive cognitions and beliefs within psychology has been implicit and also deserves further attention. If positive cognition has a similar predictive power to negative thought and beliefs, this information could be used in developing a measure for use in health promotion programmes, as well as evaluating outcomes and interventions within clinical

services. This work may further contribute by providing the 'missing measurement' within public health to which Bartlett & Coles (1998, p.286) refer. The development of such measures would be invaluable for evaluating programmes that aim to promote well-being and mental health, and to build strength. However, valid measures that reflect individual views and experiences, and consider the long-term benefits of positive factors require longitudinal studies (Stewart-Brown, 2000). Just as improvements in physical health care over the last 100 years have required a longitudinal approach and concerted effort to produce change, the Bright Futures report recognises that 'emotional intelligence and mental health do not just happen, they cost money and need skilled resources' (MHF, 1999, pg.112).

A final thought:

It may all just be semantics. What does it really matter if we focus on the 'negative' rather than building the 'positive'.

But then I remember being told about a study where a group of school children have to give one another advice about walking across an 'imaginary' tight-rope, over 'imaginary' gnashing crocodiles. When children were told 'to stand up tall', or 'look straight ahead', they were more likely to make it to the other side. When the advice was phrased differently: 'don't look down', or 'don't think about falling off', what happened? .. They were more likely to fall off ...

REFERENCES

5. REFERENCES

American Psychological Association. (1994). *DSM-IV. Diagnostic and Statistical Manual of Mental Disorders*. 4th edition. APA: Washington D.C.

Andrews,F.M. & Robinson,J.P. (1991). Measures of subjective well-being. In: J.P.Robinson, P.R.Shaver & L.S.Wrightsman (Eds). *Measures of Personality and Social Psychological Attitudes. Volume 1 in Measures of Social Psychological Attitudes Series* (pp.61-113). Academic Press:California.

Appleton,P.L. & Hammond-Rowley,S. (2000). Addressing the population burden of child and adolescent mental health problems: a primary care model, *Child Psychology & Psychiatry Review*, 5 (1), 9-16.

Armstrong,C, Hill,M. & Secker,J. (1998). *Listening to Children*, The Mental Health Foundation: London.

Audit Commission Briefing (1999). *Children in Mind: a review of CAMHS*. Source: <http://www.audit-commission.gov.uk>.

Bartlett,C.J. & Coles,E.C. (1998). Psychological health and well-being: why and how should public health specialists measure it? Part 1: rationale and methods of the investigation, and review of psychiatric epidemiology, *Journal of Public Health Medicine*, 20(3), 281-287.

Bartlett,C.J. & Coles,E.C. (1998a). Psychological health and well-being. Part 2: stress, subjective well-being and overall conclusions, *Journal of Public Health Medicine*, 20(3), 288-294).

Beck,A. (1976). *Cognitive Therapy and the Emotional Disorders*. United Universities Press:New York.

Bibace,R. & Walsh,M.E. (1980). Development of children's concepts of illness, *Pediatrics*, 66, 912-917.

Bird,J.E. & Podmore,V.N. (1990). Children's understanding of health and illness, *Psychology & Health*, 4, 175-185.

Blascovich, J. & Tomaka, J. (1991). Measures of self-esteem (pp.115-160). In: J.P.Robinson, P.R.Shaver & L.S.Wrightsman (Eds).. *Measures of Personality and Social Psychological Attitudes. Volume 1 in Measures of Social Psychological Attitudes Series* (pp.61-113). Academic Press:California.

Bowling,A. & Windsor,J. (2001). Towards the good life: a population survey of dimensions of quality of life, *Journal of Happiness Studies*, 2, 55-81.

Buchanan,A. & Katz,A. (1999). Factors associated with high and low self-esteem in boys and girls, The Mental Heath Foundation:London.

Buchanan,A. (2002). Department of Social Work and Policy, Oxford University, *personal communication*.

Burr,V. (1995). *An Introduction to Social Constructionism*. Routledge: London.

Cecchin,G. (1987). Hypothesizing, circularity and neutrality revisited: an invitation to curiosity, *Family Process*, 24(4).

- Carr,A. (1999). *The Handbook of Child and Adolescent Clinical Psychology. A contextual approach*. Routledge:London&New York.
- Christopher,J.C. (1999). Situating psychological well-being: exploring the cultural roots of its theory and research, *Journal of Counselling & Development*, **77**, 141-152.
- Clark,L.A. & Watson,D. (1991). General affective dispositions in physical and psychological health. In: C.R.Snyder & D.R.Forsyth (Eds). *Handbook of Social and Clinical Psychology: the health perspective*. (pp.221-245). New York:Pergamon Press.
- Collins Paperback English Dictionary. (1986). Collins:London.
- Coolican,H. (1999). *Research Methods and Statistics in Psychology* (3rd edition). Hodder & Stoughton:London.
- Cowen,E.L. (1994). The enhancement of psychological wellness: challenges and opportunities, *American Journal of Community Psychology*, **22**, 149-179.
- Cowie,H. (1999). Peers helping peers: intervention, initiatives and insight (Editorial), *Journal of Adolescence*, **22**, 433-436.
- Debats,D.L. (1996). Meaning in life: clinical relevance and predictive power, *British Journal of Clinical Psychology*, **35**, 503-516.
- Deiner,E. (1984). Subjective well-being, *Psychological Bulletin*, **95** (3), 542-575.
- Deiner,E., Eunkook,M.S., Lucas,R.E. & Smith, H.L. (1999). Subjective well-being: three decades of progress, *Psychological Bulletin*, **125**, 276-302.
- Deiner,E. (2000). Subjective well-being: the science of happiness and a proposal for a national index, *American Psychologist*, **55**(1), 34-43.
- Department of Health. (1998). *Our Healthier nation – consultation document*. HMSO:London.
- Department of Health. (2000). *Saving Lives: our healthier nation*. HMSO: London.
- Department of Health. (2001a). *NHS Plan*. HMSO: London.
- Department of Health. (2001b). *Treatment choice in psychotherapies and counselling: evidence-based clinical practice guidelines*. HMSO: London.
- Department for Education & Employment. (1999). *SureStart: making a difference for children and families*. H M Government (DfEE Publications): Sudbury, Suffolk.
- DuBois,D.L. & Felner,R.D. (1996). The Quadripartite model of social competence. In M.A.Reinecke, F.M. Dattilio & A.Freeman. (Eds). *Cognitive Therapy with Children and Adolescents: a casebook for clinical practice*. (pp.124-151). Guilford Press:New York.
- Eisen,M., Donald,C.A., Ware,J.E. & Brook,R.H. (1980). *Conceptualisation and measurement of health for children in the Health Insurance Study* (US Department of Health, Education & Welfare). The Rand Corporation:Santa Monica, California.
- Fava,G.A., Rafanelli,C., Cazzaro,M., Conti,S. & Grandi,S. (1998). Well-being therapy. A novel psycho-therapeutic approach for residual symptoms of affective disorders, *Psychological Medicine*, **28**, 475-480.
- Fava,G.A. (1999). Well-being therapy: conceptual and technical issues, *Psychotherapy & Psychosomatics*, **68**, 171-179.

- Fielding, N. (1993). Qualitative interviewing. In: N. Gilbert (Ed). *Researching Social Life*. London: Sage.
- Fredrickson, B. L. (1998). What good are positive emotions? *Review of General Psychology*, 2, 300-319.
- Fredrickson, B. L. (2000). Cultivating positive emotions to optimise health and well-being, *Prevention & Treatment*, 3, 1-24. (Article 0001a, posted 7 March 2000. <http://www.journals.apa.org/prevention/volume3/pre0030001a.html>).
- Garmezy, N. (1985). Stress-resilient children; the search for protective factors. In J. E. Steveson. (Ed). *Recent research in developmental psychopathology*. (pp. 213-233). *Journal of Child Psychology & Psychiatry* (Book Supplement No. 4).
- Gillham, J., Reivich, K., Jaycox, L. & Seligman, M. E. P. (1995). Prevention of depressive symptoms in school children: two year follow-up, *Psychological Science*, 6, 343-351.
- Gillham, J. & Seligman, M. (1999). Footsteps on the road to a positive psychology, *Behaviour Research & Therapy*, 37, 163-173.
- Gilman, R. & Huebner, S. (2002). A review of life satisfaction research with children and adolescents (manuscript in preparation).
- Goldberg, D. P. (1979). A scaled version of the General Health Questionnaire, *Psychological Medicine*, 9, 189-272.
- Goodman, R. (1997). The Strengths and Difficulties Questionnaire: a research note, *Journal of Child Psychology and Psychiatry*, 38, 581-586.
- Goodman, R. (1999). The Extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden, *Journal of Child Psychology and Psychiatry*, 40, 791-799.
- HAS, The NHS Health Advisory Service (1995). *Child and Adolescent Mental Health Services* (2nd impression with corrections). HMSO: London.
- Henwood, K. L. & Pidgeon, N. F. (1995). Grounded theory and psychological research, *The Psychologist*, 83, 97-111.
- Hollon, S. D. & Kendall, P. C. (1980). Cognitive self-statements: development of an Automatic Thoughts Questionnaire, *Cognitive Therapy & Research*, 4, 383-395.
- HMSO. (1989). *The Children Act*. The Stationary Office Ltd: London.
- Huebner, E. S. (1991). Initial development of the Students' Life Satisfaction Scale, *School Psychology International*, 12, 231-240.
- Huebner, E. S., Drane, W. & Valois, R. F. (2000). Levels and demographic correlates of adolescent life satisfaction, *School Psychology International*, 21, 281-292.
- Huppert, F. A. & Whittington, J. E. (in press). Evidence for the independence of positive and negative well-being: implications for quality of life assessment, *British Journal of Health Psychology*.
- Ingram, R. E. & Wisnicki, K. S. (1988). Assessment of positive automatic cognition, *Journal of Consulting and Clinical Psychology*, 56(6), 898-902.
- Jahoda, M. (1958). *Current concepts of positive mental health*. New York: Basic Books.

- Jenney, M.E.M. & Campbell, S. (1997). Measuring quality of life, *Archives of Disease in Childhood*, 77, 347-354.
- Jutras, S., Normandeau, S. & Kanins, I. (1997). Mutual help in relation to health: the experience of children, *Journal of Primary Prevention*, 18 (2), 173-192.
- Jutras, S., Normandeau, S., Kalnins, I. & Morin, P. (1998). Mental health referents within children's health cognitions, *Canadian Journal of Community Mental Health*, 17(1), 21-35.
- Kalnins, I., Jutras, S. & Normandeau, S. (1998). Children's health actions within the context of daily living, *American Journal of Health Behaviour*, 22 (6), 460-472.
- Kelley, T.M. & Stack, S.A. (2000). Thought recognition, locus of control and adolescent well-being, *Adolescence*, 35 (139), 531-550.
- Kendall, P.C. & Panichelli-Mindel. (1995). Cognitive Behavioural Treatments, *Journal of Abnormal Child Psychology*, 23 (1), 107-124.
- Kendall, P.C. (2000). Guiding theory for therapy with children and adolescents. In: P. C. Kendall (Ed). *Child and Adolescent Therapy: cognitive-behavioural procedures* pp.3-27). The Guildford Press: New York.
- Larson, J.S. (1993). The measurement of social well-being, *Social Indicators Research*, 28, 285-296.
- Lightsey, O.R. (1994). 'Thinking positive' as a stress buffer: the role of positive automatic cognitions in depression and happiness, *Journal of Counselling Psychology*, 41 (3), 325-334.
- McCulloch, G., Huebner, E.S. & Laughlin, J.E. (2000). Life events, self-concept and adolescents' positive subjective well-being, *Psychology in the Schools*, 37(3), 281-290.
- Mayall, B. (1994). *Negotiating Health: primary school children at home and school*. Cassell: London.
- Mayall, B., Bendelow, G., Barker, B., Storey, P. & Veltman, M. (1996). *Children's Health in Primary Schools*. Falmer Press: London.
- Mays, N. & Pope, C. (1999). *Qualitative research in health care*. (2nd edition). BMJ Books: London.
- Mays, N. & Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research, *British Medical Journal*, 320, 50-52.
- Mental Health Foundation (1999). *Bright Futures: promoting children & young people's mental health*, The Mental Health Foundation: London.
- Mental Health Foundation (2002). 'How can we help ourselves?' (accessed: 1 July 2002). <http://www.mentlhealth.org.uk/html/content/mentalhealth.cfm>
- Meltzer, H., Gatward, R., Goodman, R. & Ford, T. (2000). *Mental Health of Children and Adolescents in Great Britain*. The Stationary Office: London. <http://www.ons.gov.uk>
- Morrow, V. (1999). Conceptualising social capital in relation to the well-being of children and young people: a critical review, *The Sociological Review*, 744-765.

- Morrow,V. (2001). *Networks and neighbourhoods: children's and young people's perspectives*. NHS Health Development Agency:London.
- Neugarten,B.L., Havinghurst,R. & Tobin,S. (1961). The measurement of life satisfaction, *Journal of Gerontology*, **16**, 134-143.
- Normandeau,S., Kalnins,I., Jutras,S. & Hanigan,D. (1998). A description of 5- to 12-year old children's conception of health within the context of their daily life, *Psychology & Health*, **13**, 883-896.
- ONS,Office for National Statistics. (2000). *Mental Health of Children and Adolescents in Great Britain*. Office for National Statistics:London.
- Padesky,C. (1994). Schema change processes in cognitive therapy, *Clinical Psychology & Psychotherapy*, **1**(5), 267-278.
- Parker,W.C. (1984). Interviewing children: problems and promise, *Journal of Negro Education*, **53**(1), 18-28. <http://www.jstor.ac.uk/journals.html>.
- Parloff,M.B., Kelma,H.C. & Frank,J.D. (1954). Comfort, effectiveness, and self-awareness as criteria of improvement in psychotherapy, *American Journal of Psychiatry*, **11**, 343-351.
- Peterson,C. (2000).The Future of Optimism, *American Psychologist*, **55**(1), 44-55.
- Piers,E.V. (1984). *Piers-Harris Self Concept Scale: revised manual*, Counselor Recordings and Tests:Nashcille, US.
- Prilleltensky,I. (1994). The United Nations Convention on the Rights of the Child: implications for children's mental health, *Canadian Journal of Community Mental Health*, **13**(2), 77-93.
- Putnam,R.D. (1995). 'Bowling alone': America's declining social capital, *Journal of Democracy*, **6**(1), 65-78.
- Rasmussen,V.B. & Rivett,D. (2000). The European Network of Health Promoting Schools – an alliance between health, education and democracy, *Health Education*, **100**, 61-67.
- Rigby,K. (2000). Effects of peer victimisation in schools and perceived social support on adolescent well-being, *Journal of Adolescence*, **23**, 57-68.
- Rutter,M. (1987). Psycho-social resilience and protective mechanisms, *American Journal of Orthopsychiatry*, **57**, 316-331.
- Rutter,M. (1997). Connections between child and adult psychopathology, *European Child & Adolescent Psychiatry*, **5**(supp.1), 4-7.
- Robinson,J.P., Shaver,P.R. & Wrightsman,L.S. (1991). *Measures of Personality and Social Psychological Attitudes. Volume 1 in Measures of Social Psychological Attitudes Series*. Academic Press:California.
- Ryff,C. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being, *Journal of Personality and Social Psychology*, **57**(6), 1069-81.
- Ryff,C.D., & Keyes,C.L.M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology*, **69**, 719-727.

- Ryff,C.D., & Singer,B. (1996). Psychological well-being: Meaning, measurement, and implications for psychotherapy research. *Psychotherapy and Psychosomatics*, 65, 14-23.
- Ryff,C.D. & Singer,B. (1998). The contours of positive human health, *Psychological Inquiry*, 9(1), 1-28.
- Ryff,C.D., & Singer,B. (2000). Biopsychosocial challenges of the new millenium, (Editorial), *Psychotherapy and Psychosomatics*, 69, 170-177.
- Salevoy,P. (2000). Emotional states & physical health, *American Psychologist*, 55 (1).
- Shatte,A.J., Gillham,J.E. & Reivich, K. (2000). Promoting hope in children and adolescents (pp.215-234). In:C.R.Snyder & S.Lopez (Eds). *Handbook of Positive Psychology*. Oxford University Press:New York
- Schipper,H., Clinch,J.J. & Olweny,C.L.M. (1996). Quality of life studies: definitions and conceptual issues. In: Spilker,B. (Ed). *Quality of Life and Pharmacoeconomics in clinical Trials* (2nd edition). Lippincott-Raven Publishers: Philidelphia.
- Schmutte,P.S. & Ryff,C.D. (1997). Personality & well-being: re-examining methods & meaning, *Journal of Personality & Social Psychology*, 73(3), 549-559.
- Seligman,M.E.P., Schulman,P., DeRubeis,R.J. & Hollon,S.D. (1999). The prevention of depression and anxiety, *Prevention & Treatment*, 2, Art 8 (posted 21.12.99, pp.1-21):www.journals.apa.org/prevention/volume2/pre0020008a.html.
- Seligman,M.E.P. (2000). Positive psychology, positive prevention, and positive therapy. In: C.R.Snyder & S.Lopez (Eds). *Handbook of Positive Psychology*. Oxford University Press:New York. Source: www.positivepsychology.org/ppsnnyderchapter.htm (pp.1-8).
- Seligman,M.E.P. & Csikszentmihalyi,M. (2000). Positive psychology:an introduction, *American Psychologist*, 55(1), 5-14.
- Seligman,M.E.P. (2001). Positive Clinical Psychology. In: L.G.Aspinall & U.M.Staudinger (Eds). *A Psychology of Human Strengths: perspectives on an emerging field*. American Psychological Association: Washington DC. Source: www.positivepsychology.org/posclinpsychap.htm (pp.1-10).
- Silverman,D. (1993). *Interpreting Qualitative Data: methods for analysing talk, text and interaction*. Sage:London.
- Smith,J.A. (1996) Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology & Health*, 11, 261-271.
- Smith,J.A., Osborn,M. & Jarman,M. (1999). Doing Interpretative phenomenological analysis. In: M.Murray & K.Chamberlain (Eds) *Qualitative Health Psychology: Theories and Methods*. London: Sage (pp.218-240).
- Snyder,C.R., McDermott,D., Cook,W. & Rapoff,M.A. (1997). Helping children through good times and bad. Boulder:Western Press.
- St.Leger,L.H. (1999). The opportunities and effectiveness of the health promoting primary school in improving child health – a review of the claims and evidence, *Health Education Research*, 14, 51-69.

Stewart-Brown,S. et al. (1998). *Developing Measures of emotional and social well-being for parents and children*. Health Services Research Unit, Oxford:Proposal to Medical Research Council.

Stewart-Brown,S. (2000). Parenting, well-being, health and disease. In: Buchanan,A. & Hudson,B. (Eds). *Promoting Children's Emotional Well-being* (pp.28-47). Oxford University Press:Oxford.

Stiles,W. (1993). Quality control in qualitative research, *Clinical Psychology Review*, **13**, 593-618.

Strauss,A. & Corbin,J. (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. Thousand Oaks, Sage.

Taylor,S. (2000). Psychological resources, positive illusions and health, *American Psychologist*, **55**(1)..

Taylor,S.E. & Brown,J.D. (1988). Illusion and well-being: a social psychological perspective on mental health, *Psychological Bulletin*, **103**, 193-210.

Turner,G. (1999). Peer support and young people's health, *Journal of Adolescence*, **22**, 567-572.

Varni,J.W., Seid,M. & Rode,C.A. (1999). The PedsQL: measurement model for the pediatric quality of life inventory, *Medical Care*, **37**, 126-139.

Watson,D., Clark,L.A. & Tellegen,A. (1988). Development and validation of brief measures of positive and negative affect: the PANAS scales, *Journal of Personality & Social Psychology*, **54**, 1063-1070.

Weare,K. (2000). *Promoting Mental, Emotional and Social Health: a whole school approach*. Routledge:London.

World Health Organisation. (1948). World Health Organisation constitution. In *Basic documents*, Geneva: Author. <http://www.who.int>

Secondary references:

Antonovsky, A. (1993). The structure & properties of the sense of coherence scale, *Soc Sci Med*, **36**, 725-33.

Bradburn, N. M. (1969). *The Structure of Psychological Well-Being*. Chicago:Aldine.

Erikson,E. (1959).. Identity and the life-cycle. *Psychological Issues*, **1**, 18-164. Beacon Press.

Goleman,D. (1996). *Emotional Intelligence: why it can matter more than IQ*. Bloomsbury:London.

Maslow,A.H. (1968). *Towards a psychology of being*. (2nd edition). Van:New York

APPENDICES

APPENDIX 1 – TABLE 6: GLOSSARY OF TERMS

<i>Affect</i>	The subjective feelings (positive or negative) reported by individuals over a given period – measured in range of ways, for example: Beck Depression Inventory (BDI, Beck, 1976) specifically looks at negative affect/distress; the 10-item Bradburn Affective Balance Scale (BABS, Bradburn, 1969) looks at positive feelings/happiness; the 20-item Positive & Negative Affect Scale (PANAS, Watson <i>et al.</i> , 1988) looks at the difference between positive & negative.
<i>Emotional well-being</i>	This aspect of well-being is concerned with affect and how people ‘feel’ about their lives, hence essentially subjective (Stewart-Brown, 2000).
<i>Life satisfaction</i>	LS is often used to measure ‘well-being’, and a component of subjective well-being – it considers the social domains of an individual’s life (e.g. housing, income) and their appraisal of it (how satisfied an individual is), (e.g. Life Satisfaction Index, Neugarten <i>et al.</i> , 1961).
<i>Psychological well-being</i>	This term has been defined as ‘the explicitly evaluative aspect of mental functioning’ (Schutte & Ryff, 1997).
<i>Quality of life</i>	This is a patient-centred approach, differing from other physiological based measures of health. It represents an attempt to measure the impact of illness/disease and treatment on an individual’s perception of his/her ability to lead a useful and fulfilling life (Schipper <i>et al.</i> , 1996). There are difficulties with definition in this area (Jenney & Campbell, 1997) and with how the concept is actually measured (e.g. the General Health Questionnaire (GHQ, Goldberg, 1979).
<i>Self-esteem</i>	Also known as self-regard or self-worth, this refers to the extent to which individuals value, approve of, or like, themselves. It is a theoretical construct discussed more in the social sciences (but also used clinically), and can be thought of as the evaluative component of a broader representation of self (self-concept, which has cognitive and behaviour components, not just affective like self-esteem), (Robinson <i>et al.</i> , 1991). Considered to relate to discrepancy between actual and ideal self, although methodological and conceptual issues make measurement difficult, although measures do exist.
<i>Social capital</i>	This has been described in various different ways, referring to socialability, social networks, trust, reciprocity, and community and civic engagement (Morrow, 1999).
<i>Social well-being</i>	This includes impact of wider environment on individual well-being (includes social capital and social support – i.e. number/quality of relationships with others in family & community). It can be seen as ‘relationships between people which enhance rather than damage individuals’ (Stewart-Brown, 2000).
<i>Subjective well-being</i>	This aspect of well-being refers to individual perceptions of what is important in determining the meaningfulness of life (usually in relation to goals), (Deiner, 1984). It is measured by asking people what they think and feel about their lives (i.e. the affective and cognitive conclusions made when evaluating it). This aspect of well-being was based on Bradburn’s (1969) notion of happiness as a balance between positive and negative affect (Ryff & Keyes, 1995).
<i>Well-being</i>	This term is often used interchangeably with positive functioning and health, life satisfaction, happiness and quality of life. The Collins English Dictionary (1986) defined well-being as: the condition of being contented, healthy, or successful. Schutte and Ryff (1995) operationalised ‘well-being’ as affect individuals experience over a few weeks rather than moments or days (i.e. affect) or in general (i.e. personality).

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REPLY FORM FOR YOUNG PEOPLE

Study: How do young people describe what it's like to be well?

Please read your information page so that you know what the study is about.
When you have decided about the study, please tick one of the boxes below:

Please fill in your details:

Name:

Address:

Telephone Number:

Favourite Subject at School:

Favourite Chocolate Bar:

Please tick this box in your favourite colour to say:

"I HAVE READ ABOUT THE STUDY. I AGREE TO TAKE PART AND TO THE TAPE RECORDER BEING USED TO TAPE THE QUESTIONS AND ANSWERS".

Now, please sign your name:

◆◆◆THANK-YOU! NOW PLEASE GIVE THE REPLY FORM
TO YOUR PARENT/GUARDIAN TO POST◆◆◆

Jodi Pennington/AQREC/AO1.055

APPENDIX 3 - Table 7: INTERVIEW SCHEDULE

Questions	Prompts
<ul style="list-style-type: none">▪ Consent▪ Confidentiality▪ Describe study▪ After study – feedback▪ Questions?, No right/ wrong answers▪ Favourite subjects/hobbies, [SHOW SHEET: /10]	
<p>PART ONE - UNSTRUCTURED</p> <p>[SHOW SHEET -well-being words]</p> <p>Can you tell me what these words mean to you?</p> <p>That’s really great, we’ll move on now</p>	<p>(5 minutes)</p> <p><i>Have you heard them used?</i></p> <p><i>What do you think they mean?</i></p> <p><i>Explore each statement – what does that mean?, tell me more?, what do you mean, when you say?</i></p>
<p>PART TWO - SEMI-STRUCTURED</p> <p><u>Memories of a time when...</u></p> <p>(A). Okay, I would like you to think of the last/ most recent time when things were going really well, good, great. Might be earlier today, yesterday, last week, last month ...</p> <p>Can you think of the last time you felt things were going well?</p> <p>Tell me about the time when things were going okay, well...</p> <p>What else can you remember?</p> <p>What happened then/ next?</p> <p>Okay, thinking about that time and keeping it in your mind ...</p>	<p>(25-30 minutes)</p> <p><i>Okay, keep it your mind - I’ll ask you to tell me about it. I will ask questions to find out more as I wasn’t there ... okay?</i></p> <p><i>What was happening?</i></p> <p><i>When? Where?</i></p> <p><i>Who else was there?</i></p> <p><i>Smells, sights, sounds, tastes, touch</i></p> <p><i>Refer back and check it’s correct</i></p>

FEELINGS:

What kind of mood were you in, what did you feel, what feeling words describe how you felt?, when you were how did this make you feel?

*Prompt for more:
most
least.....*

Sometimes, it is hard to remember all the feelings we have - other young people have told me a list of feelings might help with remembering - have a look at the list and see if you can see any that describe how you felt at the time ... *(don't have to pick if none)*

*Prompt for more:
most
least.....*

[SHOW SHEET - feelings]

PHYSICAL SENSATIONS:

If I was an alien, how would I know what
(feelings) felt like/ that I was having that feeling? What clues would there be? Where would I feel it in my body?
[SHOW SHEET -body outline] Can you remember having any of those feelings when ...?

*Prompt for more:
most
least.....*

THOUGHTS:

Okay, when you and things were going well, what was running through your mind? *(might be words or a picture)* - **[SHOW SHEET-thoughts]**

*Prompt for more:
most
least.....*

Is that thought unusual/ do you get it often?

TELL ME MORE!

*Make sure it is a
specific example (not
general or a question)
What did that mean?/Give
me an example?/What was
(great)?/When you say
...what do you mean?/
What did you
worry/hope would
happen?*

BELIEFS:

Now STATE the THOUGHT: Okay, so you thought ...

What does that say about you? (good/not so good)

Okay, if you were thinking, what does that mean?
Tell me more.

Okay, so if is true, what does that say about you?

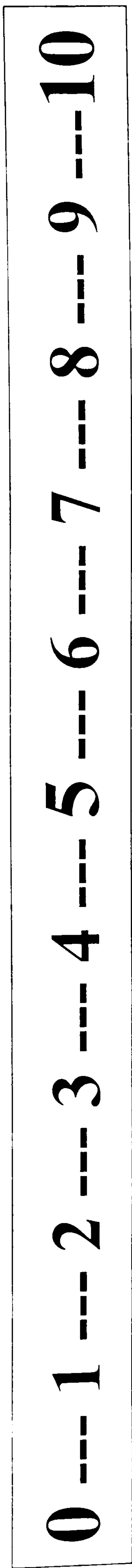
[SHOW SHEET-beliefs]

<p>Check Validity:</p> <p>So, when you thought <i>what mood/feelings do you get?</i> <i>any feelings in your body?</i> what kind of things are you more likely to do? what kind of things are you less likely to do? <i>does this remind you of other memories?</i></p> <p>(B). Okay, now I would like you to think of the last/most recent memory time when things were NOT going so well, good, great. Might be earlier today, yesterday, last week, last month ...</p> <p>Can you think of the last time you felt things were NOT going so well?</p> <p>THEN REPEAT QUESTIONS AS FOR (A).</p>	<p><i>That's great, thank you!</i></p> <p><i>Okay, keep it your mind - I'll ask you to tell me about it. I will ask questions to find out more as I wasn't there ... okay?</i></p> <p><i>That's great, thank you!</i> <i>We've nearly finished!</i></p>
<p>PART THREE: CONCLUDING</p> <p>TOP TIPS:</p> <p>[SHOW SHEET-'top tips']</p> <p>What would be your 'top tips' for keeping yourself well? Tips (advice) for other children your age to keep well? Tips for adults (teachers/parents) to help children your age to stay well?</p> <p>FEEDBACK - and give thank you letter to child:</p> <p>We have finished now. Do you have any questions?</p> <p>What was it like to take part in the study?</p> <p>What bits were easy/hard, interesting/boring?</p> <p>Is there anything else you want to say?</p> <p>Thank you for taking part, you did really well</p>	<p>(10-15 minutes)</p> <p><i>Tell me some more about that....</i></p> <p><i>(total time:45-50mins)</i></p>

How are things going for you at the moment?

Thinking about your life at the moment – at home, school, with friends, things you like doing – how well are things going for you?

Where would you put yourself on this scale?



As bad as
things
could be

As good as
things
could be

Well-being

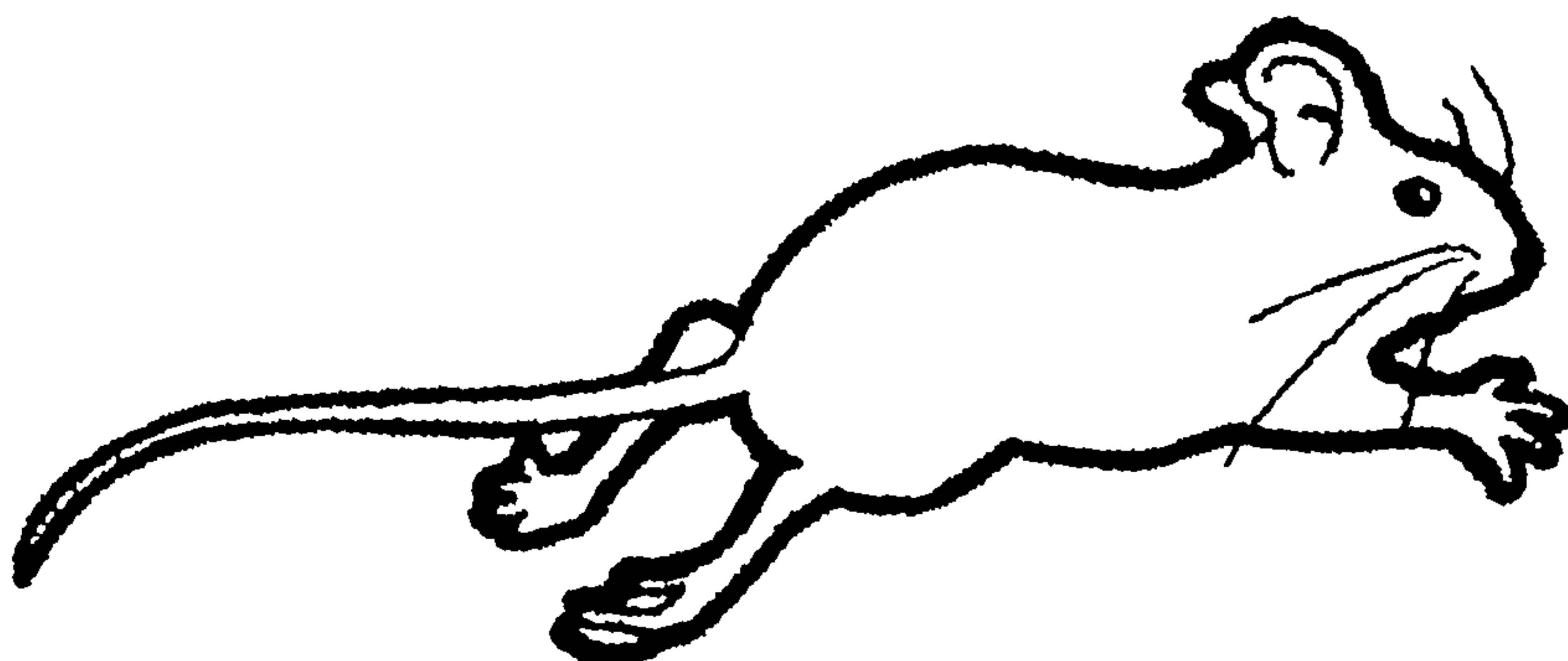
Wellness

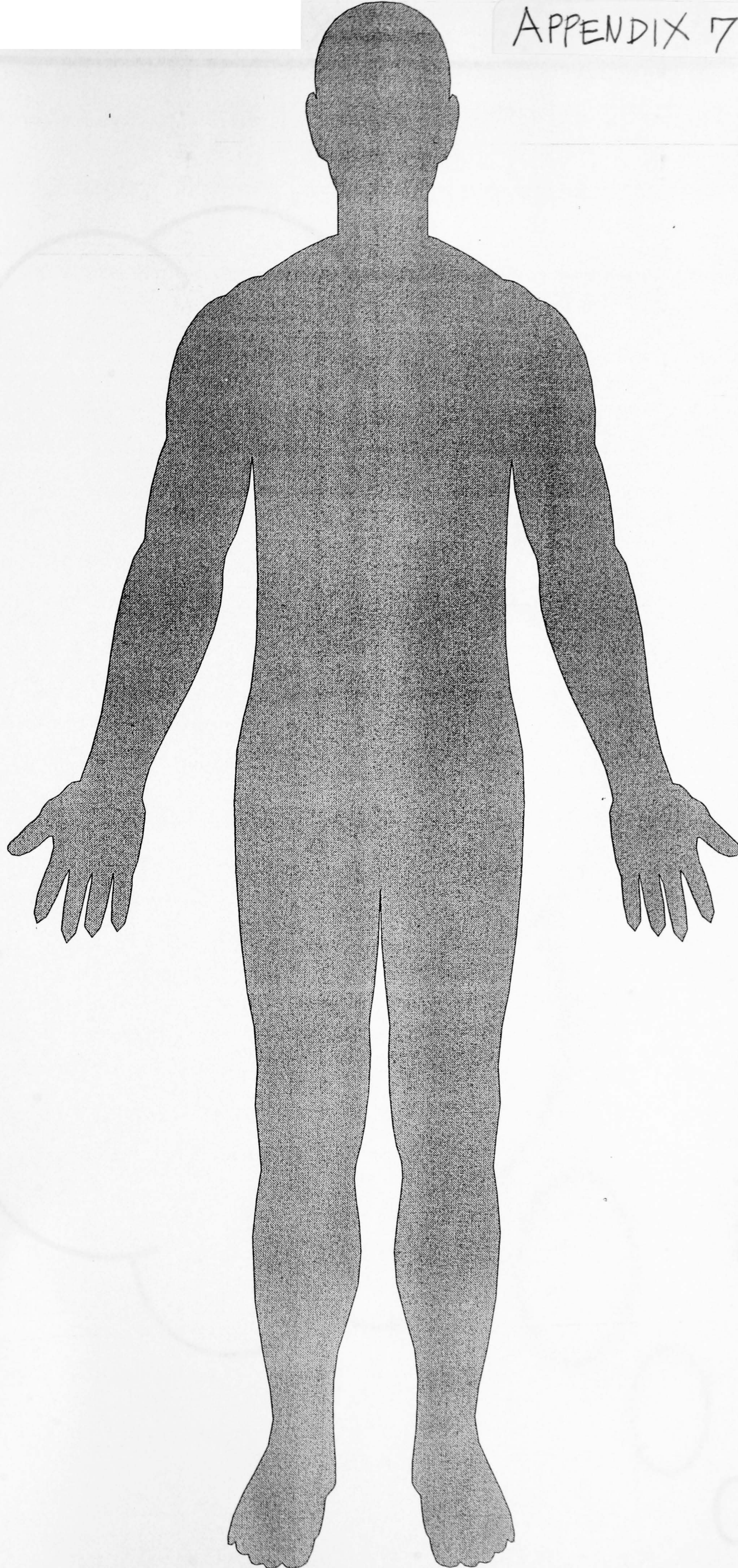
Being Well

These are some feeling words. Have a look at them and tell me if any of the words describe how you felt at the time you are thinking about.

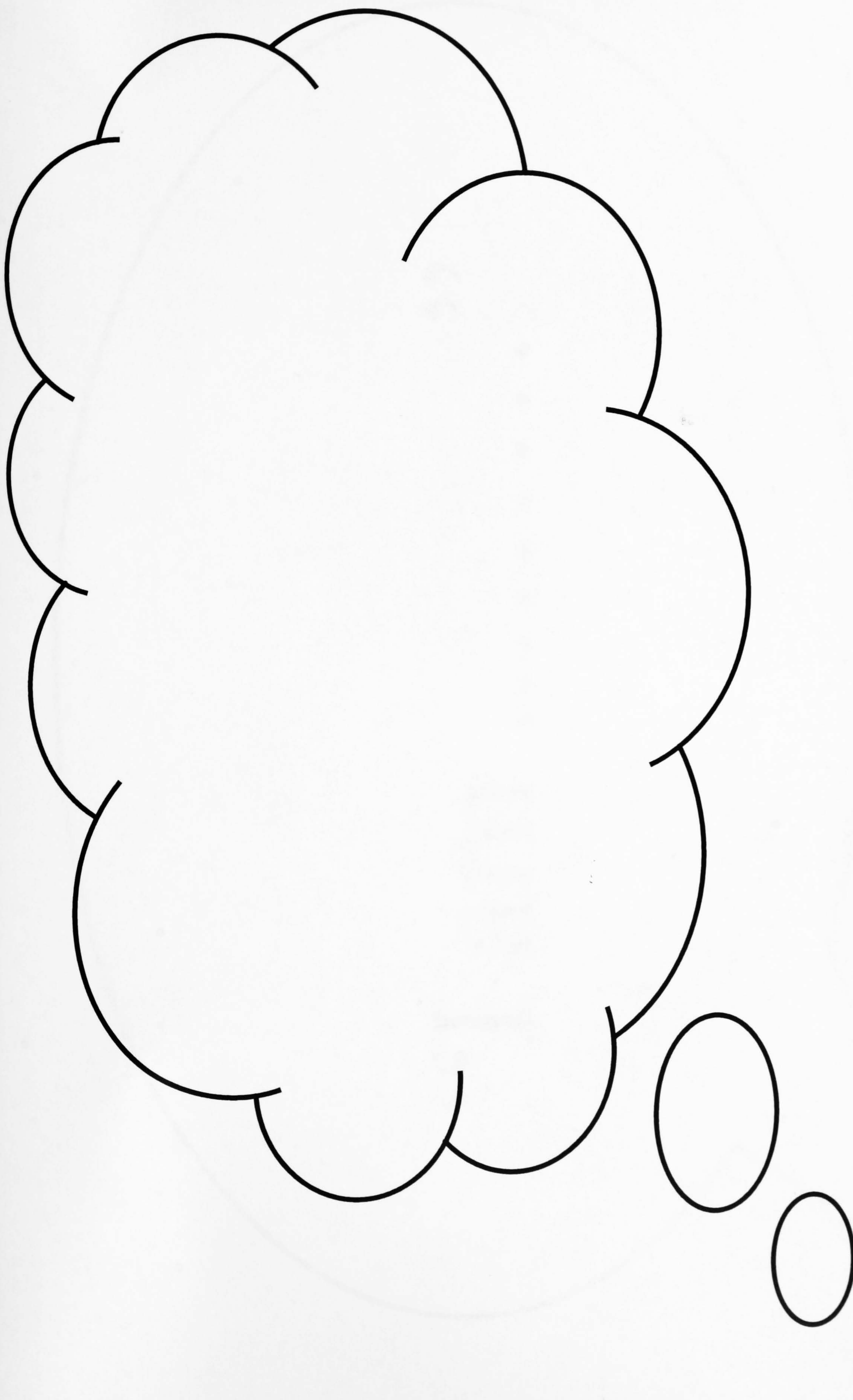
These are not ALL the feeling words that exist – you might think of some others. It is also okay if none of the words describe how you felt.

sad	cross	bubbly	excited
happy	down	frightened	enthusiastic
sorry	left out	calm	fed up
hurt	bored	nervous	lost
helpful	liked	open	friendly
relief	mad	worried	weak
horrible	shocked	caring	sick
love	bad	guilty	supported
important	brave	confused	quiet
angry	scared	confident	relaxed
depressed	lovely	frustrated	safe
strong	surprised	alone	shy
useful	embarrassed	stupid	pleased
disappointed	sociable	nasty	empty
wanted	useless	great	funny
positive	proud	different	nice





What was going through your mind?



“I am”



TOP TIPS

Today, I have been asking you questions about well-being and how you feel and think when things are going well for you. Have a think about what things are important in your life to help you stay well and feel life is going okay.

What would be your three 'top tips' for staying well?

- 1.
- 2.
- 3.

What 'top tip' for keeping well would you give to another young person your age?

.....
.....

What 'top tip' would you give to adults (parents/teachers) for helping young people your age to keep well?

.....
.....



Oxford Doctoral Course in Clinical Psychology

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Head Teacher

Dear *(Head Teacher's name)*

**Study undertaken as part of Oxford Doctoral Course in Clinical Psychology:
Children's Understanding of Psychological Well-Being**

I would just like to say a big thank you for your support of the above study. I know that schools are busy places but I am grateful that you took the time to meet with me, be interested in the project and decide to take part. I have been impressed with all the help I have received from schools and I have enjoyed meeting children that have taken part in the study. Many thanks also to your school administrator who helped with my many telephone messages and enquiries.

However, I would particularly like to recognise the effort children made to return their consent forms, and their openness and enthusiasm during the interviews. It was a real pleasure to meet with pupils from *(school's name)*. Please find enclosed a certificate for each of the children I interviewed. This is just a small acknowledgement of their contribution. I would be grateful if you could pass these on to the children in whatever way you feel appropriate.

I will complete the study in July. After this time, I will contact children and schools that took part to send a summary of the findings.

Many thanks once again and best wishes.

Yours sincerely

Jodi Pennington
Trainee Clinical Psychologist

Encs

Oxford Doctoral Course in Clinical Psychology

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Tel: 01865 226431/226374 ♦ Fax: 01865 226364 ♦ e-mail: maxine.pribyl@oxmhc-tr.anglox.nhs.uk ♦

Dear

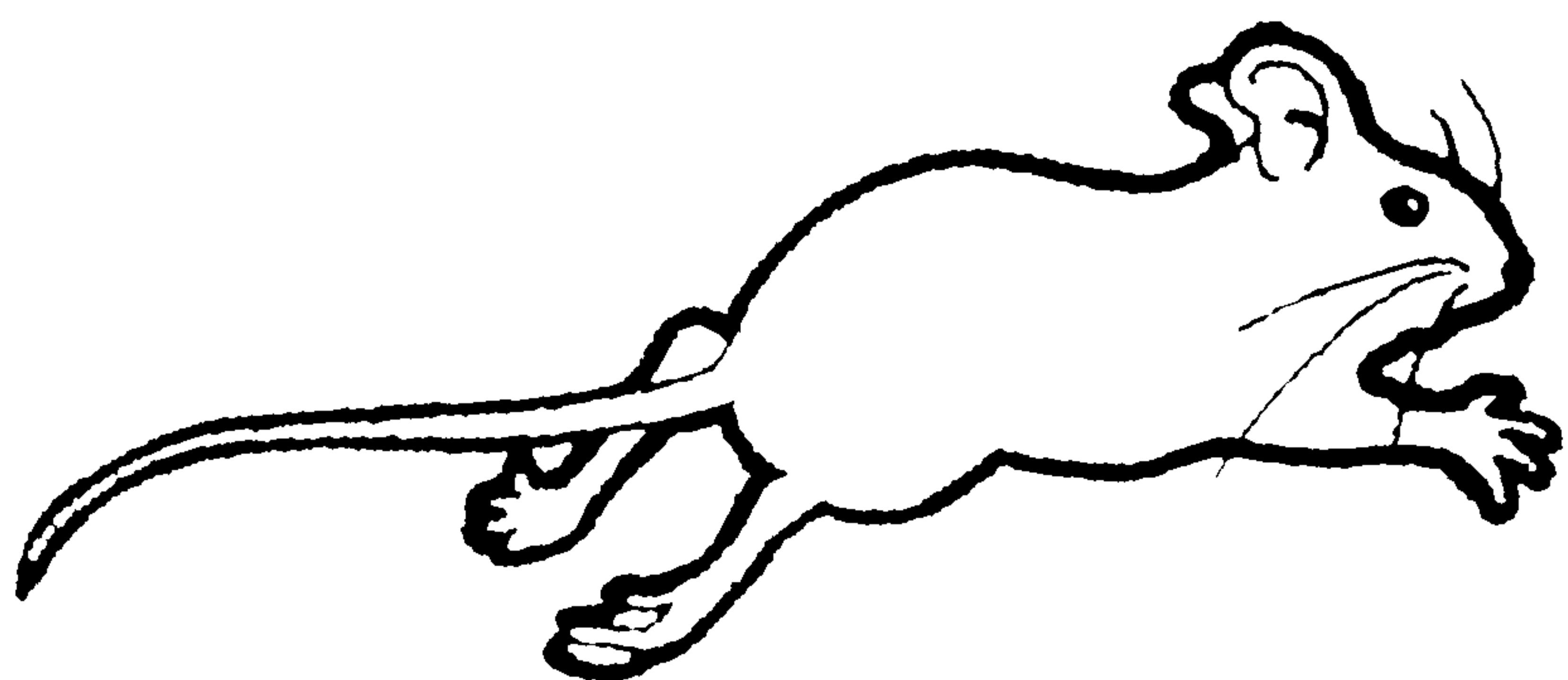
This is just to say a very **BIG** thank you for agreeing to take part in this research. You have made an important contribution to the study.

Next summer, I will write to you with some information about what all the young people have said in the study - to let you know what I found and how it could be helpful to others the same age.

If you have any questions or thoughts after taking part in the study or want to tell me what it was like, you can always write these down. You can send them to me at the above address (but only if you want to).

A very **BIG** thank you again. It was really nice to meet you.

Jodi



OXFORD DOCTORAL COURSE IN CLINICAL PSYCHOLOGY

This certificate is to say a **BIG** thank you to

.....

for thinking hard



and taking part in a study about young people's understanding of well-being.

Signed: Date:

Our Ref: JB/SKH/AM01.055

Dr M Cooper
Oxford Doctoral Course in Psychology
Isis Education Centre
Warneford Hospital
HEADINGTON
Oxford OX3 7JX

Applied & Qualitative Research Ethics Committee
Research & Development Department
Room 13, Manor House
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Tel: 01865 222758
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Email: samantha.hatzis@orh.nhs.uk

18 October 2001

Dear Dr Cooper

Re: A01.055 - Children's Understanding of Psychological Well-Being

Thank you for your letter dated 10 October 2001, addressing the concerns raised by the Executive Sub-Committee at their meeting held on 17 August 2001. In accordance with the authority set out in the Terms of Reference I can now confirm local approval and wish you every success with the study.

Please would you add the AQREC name and your study number (A01.055) to all the information sheets and consent forms. Please would you send copies of these documents as soon as possible so that our files are complete.

Please note:

- Ethical approval is valid for three years from the date of this letter. Annual updates of the progress of the research and a report of the outcomes are required. (A reminder letter will be sent when these reports are due).
- No significant changes to the research protocol should be made without appropriate research ethics committee/chairman's approval. Any deviations from or changes to the protocol which increase the risk to subjects, or affect the conduct of the research, or are made to eliminate hazards to the research subjects, should be made known to AQREC.
- AQREC should be made aware of any serious adverse events.
- Whilst the study has received approval on ethical grounds, it is necessary for you to obtain management approval from the relevant Clinical Directors and/or Chief Executive of the Trusts (or Health Boards/DHAs) in which the work will be done.

I should be very grateful if you could send me a copy of any publication that may arise from this study.

continued

APPENDIX 14 - Table 8: Excerpt from interview transcript (coding themes)

CATEGORIES	EXCERPT FROM INTERVIEW (NUMBER 17)	THEMES
Not ill	I: Ok, ok, thank you, [ok]. Next thing I want to do is I am going to show you a piece of card and on it it's got some words and I want you to just have a look at the words and I want you to tell me what you think they mean.	INACTIVITY 'v' ACTIVITY
Forced inactivity, Illness symptoms	R: Mmm, mm like not ill, just [uh-hu] being well, wellness, mm, but .. yeh, pretty much. I: So not being ill [yeh] and being well ... So what does it mean to not be ill? R: Mm, not being like sitting like sit.. lying at home uh, like at the beginning of school, feeling really sick and spewing. I: So, being ill is being sick, lying at home. So, what's not being ill? R: Not being ill is coming to school, feeling quite happy, just generally hanging out with your friends	
'Normal' activity - school, Happy, Friends	I: So being at school, hanging out with friends [uh-hu] and being happy [yeh]. So, wha.. what's happy, tell me a bit more about what you mean (to be happy) R: Happy, just like enjoying your friends company, pretty much I: Ok, so enjoying friends company [uh-hu], anything else about being happy? R: Mmm..... no not really I: Okay, that's fine. Mm..	
Saving money & realising he can buy s'thing	R: Actually, actually, one more thing [ok], mmm, mm being happy is like mm, like just like realise that you've got like mmm, like, cause I've saved up loads of money mm, [yeh] and I'm just realising that I've got like fifty pounds, I mean.. I: Ok [that's quite], so realising you've got some money R: Yeh	PEER RELATIONSHIPS
Achieved goal, recognise success	I: You've realised that you've got some .. and that makes you pretty happy [yeh] .. ok .. R: You're like 'Yesss'. I: So, being well is about.. just to recap, being well is about not being ill so not being sick and lying at home [yeh], it's about being happy , being at school and kind of having friends [yeh], and being happy is about realising that you got some money [laughs] .. and err, enjoying your friends company R: Pretty much, yeh I: What makes you happy about enjoying friends company and realising you've got some money?	
Pleased with self, Satisfied	R: Mm, well, realising you've got some money is just satisfying [ok], and mm, mm having, just hanging out with my friends in general is just like you can talk to someone ... mm, and you can tell they won't tell anyone, so I: so something about being about to talk to someone and know that they're not going to tell someone else R: yeh	
Shared activity, friends support, can talk to & trust	I: and satisfying, why is realising you've got money satisfying? R: Mm, because it's just like .. you think 'mm I've been saving up money for a while, I wonder how much I've got and you just count it and like 'oh, yes!' (laughs), so you can realise that you can just go and buy something. I: Ok, so it's about .. reaping the rewards of saving, but also knowing that you've got some money [mm] if you do want to go and buy something R: Yeh	CHOICE
Savour moment, having choices	I: Ok, ok, that's pretty good, anything else about those words or have you pretty much summed it up now? R: Yeh, I've summed it up I: Ok, [that's ok].... Well done, next thing I want you to do is I ask you to think about the most recent time, the last time that you remember feeling that things were going pretty well, everything was pretty good, yeh,... it might have been yesterday, today, last week, last month [mm], the most recent time you can think about. R: Mmm, . probably, mm, at the weekend ... last weekend yeh I: Ok, so tell me a bit about what happened? R: Well, mmm, me and my friend J* and his friend M* went into town and mm like we just and mm we just bought loads of really cool stuff and it was really enjoyable I: Ok, so you went into town with friends R: Yeh, just and mm like cause J*'s dad was like kind of around, I mean.. I: Ok, so he'd kind of taken you in and stuff R: Yeh	
Shared activity - with friends, buying things	I: and you went and did your (own thing) R: Like say I' run out of money I'd of just go to J*'s dad and like I'd say 'can I borrow some money and my mum will pay you back' I: Yeh, ok, ok so you went into town with friends ... You said it was enjoyable [mnm], how, how else did you feel about it? [Umm?] What sort of mood were you in? R: I was in.. in a generally good mood cause mm, well the last one of J*'s friends I met was mm, B* and he was an American kid and I don't really like him and not the fact that he was American but just cause he was just really tight to me and.. I: Right, but this time J* had brought along (someone who) R: Yeh, he was nice I: And he was nice was he? Ok, so you had met somebody new [yeh] and that had gone well [yeh]. Ok, so you were feeling in a good mood, it was enjoyable, any other feelings? (that you had at that time) R: Mmm, I was a bit irritated cause, we went into a shop and I saw something I wanted to buy, and mm, then like, I didn't have time to decide that I actually wanted to buy it cause it cost forty pound [right], and mm, then I, so I we left it and they, J* and M* wouldn't go with my dad the next day but mm, it was ok.	
Some independence but adult around if need help		SHARED ACTIVITY-PEERS INDEPENDENCE
Good mood, Being left out		ADULT SUPPORT
Getting on with friends, new friends		POSITIVE MOOD PEER R'SHIPS- EXCLUSION
Missing out on things, Parental support		POSITIVE PEER R'SHIPS NEGATIVE FEELINGS CONSTRAINTS PARENT-SUPPORT

APPENDIX 15: RESEARCH DIARY

A research diary was kept throughout the research process - rough notes from meetings, reading, and reflecting on the process of research. Extracts are shown below.

December 2000 - Met Dr Stewart-Brown at Health Services Research Unit with Rupert (fellow trainee) to discuss potential areas of research, including well-being.

January 2001 - Discussions regarding 'well-being' as clinical topic for dissertation. Myra Cooper joint-supervising, discussions about how it is measured in health services. Brainstorm what well-being is and try to understand how well-being is conceptualised. Preliminary literature searches and reading.

Consider how thoughts and beliefs relating to well-being might be elicited (use semi-structured interviews?). Could use cognitive model & consider positive cognition.

February 2001 - Our individual experience and interests leads to different studies. Rupert uses a quantitative study with adults. I am interested in working with children and chose exploratory approach - due to lack of literature in this area. I begin considering practical considerations (e.g. where I see children (schools, youth clubs), how (e.g. individually, in pairs or groups) and numbers.

March/April 2001 - Draft proposal developed with Myra - focus on time plan and rationale. Develop tentative interview schedule. Continue literature review (helpful Rupert and I can share ideas, supervision also more interesting looking at well-being from different perspectives). Supervision often returns to question of what well-being is - more than just *absence of illness/distress*?

Recognise importance of taking account of broad psychological/public health/medical background - will be a big job! Find Ryff measure of psychological well-being with thorough background to area. Complexity of different definitions of well-being (psychological, emotional, etc), also consider the cognitive angle. Concerns about a 'bitty' study. Presented proposal to peer group - enthusiastic and helpful feedback. Good to have to get head round area but realise diverse literature I am drawing on and hard to make sense of it all.

May-June 2001 - Submit final proposal to external examiner and approval given with suggestions for further and wider reading. Pleased they were supportive of qualitative project. Ethics proposal submitted.

July 2001 - Supervisors felt sample of convenience ok for exploratory study and schools probably too busy to recruit. However, spoke to helpful Educational Psychologist, who recommended some schools in her patch. I telephoned all five schools - very positive response.

September 2001 - Visited schools to discuss study. Lots more effort to do five schools but wanted range of children and interesting to see different settings, what information they wanted, etc.

Ethics want minor changes. Also thinking about methodology - people suggest grounded theory. After doing MSc, want more than content analysis but not sure re. grounded theory either. Kate, psychologist on my placement, used IPA for her thesis and liked it. Spoke with her and read articles - liked its recognition of researcher bias and focus on individuals.

October 2001 - Set up provisional interview dates. Develop schedule, complete three pilot interviews (children of staff). Nervous but enjoyed interviews (three bright, articulate girls so needs to be accessible to others). Gave me lots of feedback. Think I

could be quicker picking up and feeding back assumptions and beliefs for more details. Also too quick re. follow-up questions, slower! Need better microphone.

Met with Ann Buchanan, Social Work Dept, Oxford Uni. Very helpful to talk about her practical experience of interviewing and having different ways for children to respond (e.g. visual/ written/oral presentation of materials). Also: influence of setting; importance of explanations of study; using 'top tips'. Reflected on MSc work with bereaved children, shouldn't forget to use what I learnt there in interviews.

November 2001-January 2002 - Conduct interviews across five schools. Response very good from first schools approached so disappointed when less from City schools. Also less boys than girls but remind myself it is an exploratory study. Practically, things work well. I enjoyed interviews, schedule works! Hooray. Sometimes felt had to move children on due to time but knew interviews would be too long to transcribe if kept going!

Schools helpful (noticeable difference in facilities/quiet spaces available). Children very open and relaxed given only meet them for 45-60mins. Phew! - most are able to consider and reflect on thoughts and experiences (as predicted but with fingers crossed). Also as hoped - they say well-being more than just absence of illness. All said they enjoyed interviews, some echoes from MSc data about what children value. Some choose to talk about difficult experiences (& some deliberately didn't). Sometimes unsure if my responses were those of interviewer or clinician. Some children double-checked others would not listen to the tapes.

Tried transcribing and each one takes 7-8 hours! Hari (fellow trainee) does two (in lieu of coding I do for her project). I begin putting off transcription because such slow work. After indecision (feeling I was copping out), finally send rest to be done/paid for. Realised hours spent transcribing would be better used in analysis.

Also on systemic placement and this influenced my approach. Using idea about neutral, 'curious' stance. Encourage children to explore beliefs and attitudes in detail. Ongoing dissertation supervision with Sarah and Myra useful to prompt forward movement, but feel quite autonomous which is good. Rupert and I both going well and enjoying studies, with positive feedback from participants.

January-February 2002 - Writing essay about positive well-being - useful as reading relevant literature but hard to pin ideas down in this area. Reading more 'positive psychology' literature. Good framework for well-being stuff. Need more child focused stuff.

March 2002 - Realise dissertation been on backburner due to placement, essay and RCA. At least reading relevant literature for essay.

Reading transcripts and about IPA for data analysis. Like it but how will the 'doing it' bit work out! Feeling worried about word limit. Feels very constraining if using verbatim quotation, transcript examples, explaining methodology thoroughly, using research diary. All in 25,000 (including references and appendices!!). Daunting. Spoke with Course who were sympathetic but any change won't benefit me!

First draft of methodology one Sunday morning. Great but depressing to realise if I always worked that productively, I'd be finished by now!

April 2002 - Finished placement and handed in work. Went to Tavistock - good break away with course and from dissertation, thinking about wider perspective a bit and catching up with peer group. Also, sunshine.

Straight after, met with two researchers in Cambridge re. positive psychology, exchanged ideas, and felt a long way away from initial ideas over a year ago! Also realised how interested I was in following up these ideas in future. I heard you were supposed to hate your study by now? Maybe that comes later...

Take stock after hectic few months with study leave. Pull together method and draft of introduction. Do some analysis – feels a bit woolly but interesting when get going. Most of transcripts back - expensive but feels like progress. Re-reading and reading these – noting ideas down.

Contacting more people on the web, such a useful resource. Interesting information from Canadian researcher looking at children's health cognitions (closest found to my work). Also found IPA group on net – forum for sharing ideas and invaluable to be able to ask questions. Met Ann Buchanan again – helpful to think with her about overarching themes of preliminary findings and implications. Felt excited. Also exchanged papers with someone in dept interested in well-being.

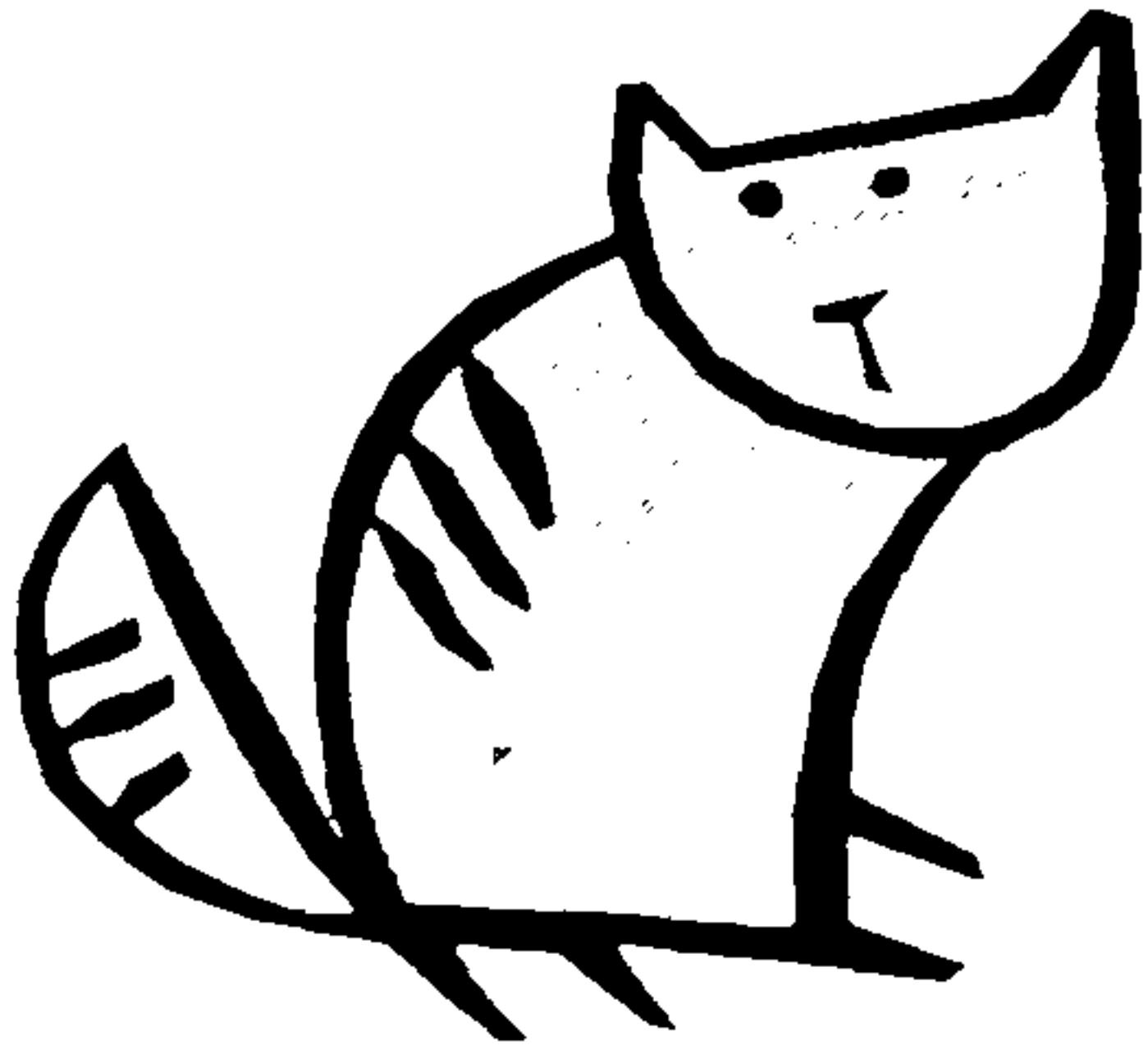
Writing introduction is hard with lots of papers from diverse areas. Ned to cut well-being literature and more on child stuff. Find some child measures currently being developed - get them via email – Praise Be To The Web!! Can get bogged down by literature though and should focus on analysis.

May-June 2002 – Passed essay and RCA – great relief. Continue reading transcripts and listening through tapes. Pulling together intro, references and appendices (good planning or procrastination?). Need to use sociological and educational ideas, as well as health stuff (QOL, self-esteem, well-being). Arghhhhh! Hard to fit in without 'bitty' feel I feared earlier. Hovering between thinking data is interesting and worrying have nothing to say/will be impossible to write up! Weeks ticking away...

Study week in early June. Everyone else seems to be going on holiday! Check preliminary categories with participants interviewed at North Hinksey School. Got on with writing – coding and doubling back to transcripts already done is very slow going – interesting but slow!

July 2002 – Coding and checking takes ages! Every time change slightly, need to go back. Very aware of subjectivity of approach – and constraint of word limits in presenting data. But then everyone else seems to be struggling with the same thing, and can't see that using stats is as 'scientific' as advertised!! Enjoying project and feedback from supervisors helpful. Wished I read more self-esteem stuff earlier – feels a gap and too late now. Very related. Oh well, soon be there.

Went to positive psychology conference – interesting but tired as so close. Looking at data right up to end, pulling everything together. Discussion interesting but time pressure takes over somewhat. Can't believe how long it all takes despite starting things in good time – hard to truly 'discuss' data while being so careful not to overstate findings. Hand-in tomorrow, lots of things I might now like to do slightly differently, but hey-ho ...



Dear

Can you remember that around Christmas time, you did an interview for me about well-being? I asked you questions about how you feel and think and the kind of things you do when you are well.

I wonder if you could help me a bit more ... I am trying to use all the brilliant ideas that you and others your age gave me. I have sorted what everyone said into categories. On the other sheet of paper, you will find lots of different things that people your age said were important about being well.

I want to ask you what you think about these things. Have a look at the sheet and think about what you think well-being is (and if you can remember, what you told me!).

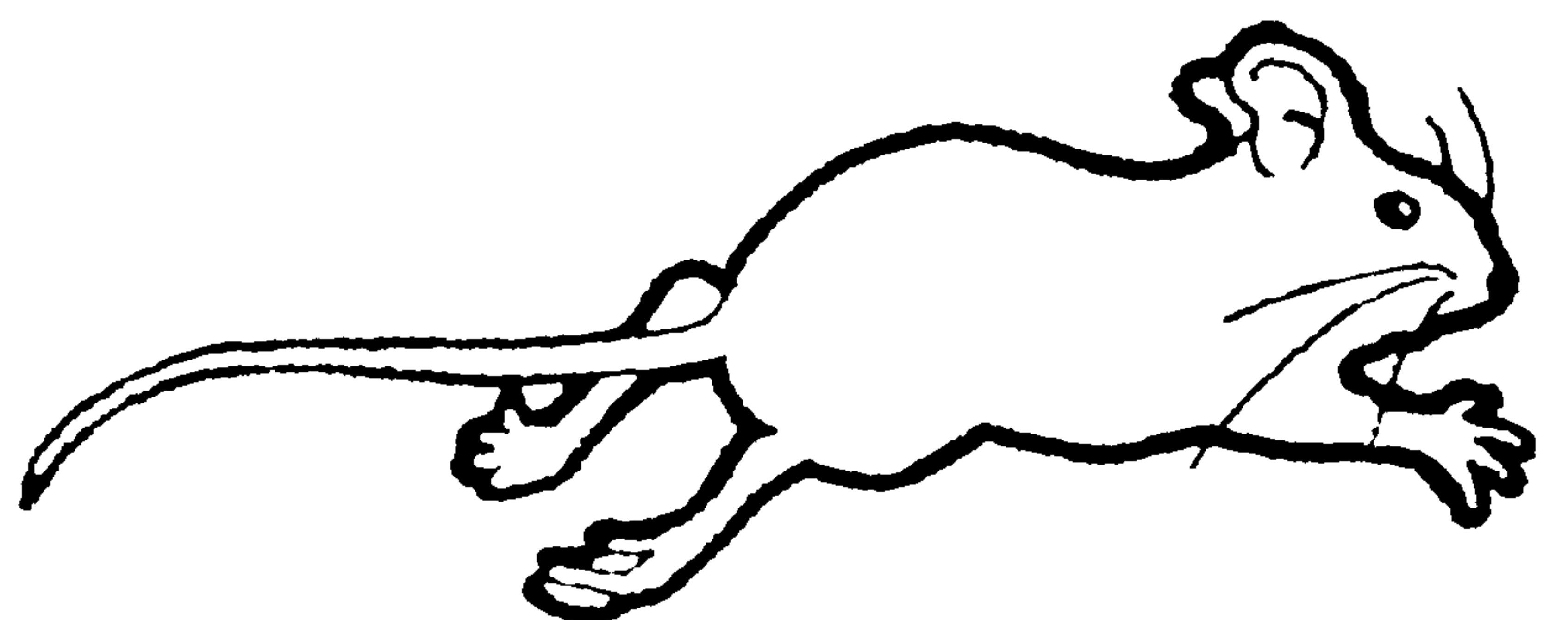
- You can tick in the right hand column if you agree - or put a cross if you don't - with the ideas
- What do you think of the way the ideas are put together?
- Do you disagree with anything or think it could be put better?
- Do you want to add anything that you think is missing?
- Do you have any other ideas or comments?

I am very interested in what you think. It is ok to write any ideas that you have and it is ok to disagree if you think something is not right. Please write your ideas and comments in the box at the bottom of the other sheet.

Thank you - and I hope you have a nice half term! Like I said when we met, I will send you a letter after I have finished my study in the summer.

Best wishes,

Jodi Pennington



I asked you what WELL-BEING, WELLNESS and BEING WELL mean to you ...

People have told me these things are important:

tick if
you agree
with ideas

A. Being well in myself

1. Being well in your body

- not being ill: because you're sick; stuck at home; feel weak, horrible & bored; can't do much
- body is well: it is important to be healthy, well & strong
- doing things to look after yourself: cleaning your teeth, not eating too much chocolate/bad food, eating well, doing activity (like running), not doing dangerous things
- being well in your body means you can do things and be normal - you can try new things and go places and do things you like doing and go to school and be playful. You can do active things like sport and art or relaxing things like listening to music

2. Being well in your self and your mind

- being yourself: being happy with yourself and who you are, not trying to be someone else
- how you feel (your mood): feeling fine, well & free, being happy and relaxed, enjoying life
- how you DON'T feel: not feeling sad, upset, down, angry, down, worried about things
- how you are at the moment: everything is ok (at home, school, family), you are doing alright, nothing is wrong (e.g. being bullied), being normal (e.g. better after ill)
- thinking about the future: if you do well at school you will get a good report or better job
- having good things happen: having a good time, surprises (presents, going out)

3. Being well in the things you are doing

- being involved with things: like doing activities, being in clubs, being with friends
- having choices & doing well: realising you've saved some money, being told you've done well, being independent (going into town, hanging out with friends, parents don't do everything)

B. Relationships with others

- doing well in your relationships: with friends, brothers and sisters, parents
- having friends: to hang out and do things with, to check things out with, to tell things to
- feeling supported by others: love from your family, sharing things with friends, trusting friends (and they can trust you), being told you've done well
- giving support back to others: being with people, helping others out, respecting and caring for others, being with others as you would like them to be with you
- how you should behave: being good, doing as you are told, being on your best behaviour

3. Other things

- other people: knowing you are doing ok and others might be worse off than you
- school: doing well is a good thing, it means you can choose in the future
- belonging to social groups: friends, family, class, activities, community
- feeling safe and secure (having your own home, in the community)

WHAT DO YOU THINK? (write more on the other side if you want to)

APPENDIX 17 – Table 9: Themes present in each transcript *

	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.	18.	19.	20.	21.	22.	23.
1.a.i.	12	1,2,4,5	1,2	1,5,15	1,3,4 5,8,11	1,2,3 6,7,9	1,4	3,10, 14	1,2,11	1,2,6, 11	1,2,4,6-8 10,12,13	1,2,3,4 6,8,9	1,4	1,4,5 8,9,10	1,2,6 10,11	1,2,3,5 7,8,9	1,3,13	1,2,3,4,6 9,10,11,12	1,5
a.ii.		3,4	1,2,6	4,5,7,10 12,13,15	45,6 9,10	1,2,3 9	9,11	2,10	8,10	1,2,5 11,12	1,3,5-7 9,11,12	1,2,4,5 10,11	1,6	3,4,8	2,4,5,7 10,11		2,7,12	3,10	6
a.iii	5	10	1	1,3,4,5 7,15	3		4				6,7,11, 12	6,7,11			4	2	10,12?		4,8
a.iv.	1	1,5,7 8,9	1,8	4,10	2,5,8 11	1,2,7 9,10	9,12	6,9,10	9,11	2,8,9	1,2,4 7,8	1,2,3	1,5	1,2,6, 7,8,9	8,9	2,8,9 10	9	1,2,7,8 9,10,11	8,9
a.v	1,2,5 10,11	4		1,3,13, 14, 15	2	1,2,5, 6,7,12 13,14	7	5,13	5	1,2	2	1,2,11	3,4		1,2	2,8,12		10,11	
	2	2,3		3,4,5 6,7	3		10	3,4	1,2 14		1,4,5,6 7,12	2,3,5,6	2	3,4		3,7,9		2,3,4 5,6	4,5,9
b.ii.	1,7 8	2,3,7	2	3,8,12 13,16	9	11	4	8	14	5,8,9	4,5,9	3,5,6		8				6,7	
2.a.		2	5,8,9	5	12		12	13			12	7,9,11	4			7	2		11
b.i.	2,3,4 5	2,3,5,7	2,7,8	1,2,12	1,4,11	2,4	1,5	5,6,12 13,14	15	1,3,4	2,3,4		1,2,3 4,7	1,4,5,6, 8-11	2,3,4,5 8,11	7		1,2	1,3,7,8
b.ii.	3,4			4,5,6,14	2,4	1,2,4 7,9	1,3,8,9		1,2,3,4,6 ,15		1,5,6,7	4,9	7,8	1	10,11	1,7,10	2,3,4,5 6,7,10	1,12	3,4,9
c.i.	1,2,4,5, 6,8,9,10	2,5,7,8 9,10	1,7,9	2,6	2,3,10 11	4,6		2,11, 13	15	3,4,5, 6,7,11	1	1,11	1,3 6,7	1,2,11	3,4,5,6	1,2,6 7,10	2		2,3,9,11
c.ii.	1,6,7 8,9	2,5,6,7 8,9,10	5,6	2,6,8	9,10,11	6,7,12 13	2,12,13	3,8	2,3,14	3,6, 11		10,11	6,8	2,9	2,4,5-7 9,11,12	1,6,7 8,9	12,13		1,2,8,11
c.iii.				2,5,9,14	2,3	4	2		4,5,7 12		8	7,8	5,6			4,6,12			
c.iv.	8	7,9,10	5,7	14		12		13	11,12			8,9,10	4	7		4			5
c.v.		5	1,4,7 8	15		6,11	9,10,12, 13	2	2,3,15	3,4	2,4	2	2,7,8	11	5	10,12			1,3,9, 10,11
c.vi.	3,6	1,3,4,6 8,9,10	4	1,10,14 15,16	11,12	6	1,2,4,5,6, 7,8,11,12		7,8	1,7	3,5,6,7 8,12	9				3,5,6,7 10,11	3,11		1,2,6,10
3.ai.	11			1,2	2,6,7		5,6,7,8		1			2	2			11		4	3
a.ii.	7,8	1,6,7,8 9,10		6,14,15	7,8	9,10	4,6,10, 11	4,6, 13		4,5,8,9 10,11	3,5	7,8	4,5,6		2,4,10	7,8	3,4,12, 13	7,9	8,9
b.	6	6,7,8	3	1,8,9,10,12 13-15,16	6,7,9	9,12, 13,14	1,3,6,7	6,9, 12	1,2,3 14		2,6,7,9, 10-13	3,7,11	7	4	7,8,9	8,12 13	2,4,5,7,9 10,11,13		1,4,6,7,9 10,11
c.		2,6			2	8,10	1,4,8,11	9,11	9,10, 12,13	5,6,7, 10	4,7,9,11	8,9	1,2,3 4,5	5,6,10	6,9	1,2,5,6, 7,10,12	6,8,9, 10,12	7,8,9	2,8,11
4.a.	11	3,4,5,10	9	2,3,5, 6,16	13	13,14	1,2,9,10 12,13		13,14 15		4,10,12	2,5,10 11	2,8,9	11	10,11,1 2	4,8,10 13,14	10,13 14	12	12
4.b.	2,10,11	5			12,13	8,10, 11	2,6,9, 12,14		14,15	12	13	10,11	8,9			1,2,4,5,8,9 10,12,13		3	2,7,12

* : This table shows themes across participants’ interview transcripts: with participant numbers across top, and themes down left side. Each cell shows page refs for themes in text.
Note: Participants 1-3 were pilot interviews and not coded; participant 4 was first interview and audio-tape recording of poor quality so that data was used but not formally coded.

NB: Any research which will be conducted on NHS patients or staff, and which has been approved by a research ethics committee must be carry the appropriate indemnity. May I remind you that AQREC final approval is contingent on the appropriate indemnity being in place.

Yours sincerely

11 S.K. Harris

Dr Jenny Butler
Chair
Applied and Qualitative Research Ethics Committee

Applied and Qualitative Research Ethics Committee (AQREC)		
AQREC No:		
Title of Project:		
The following documents have been reviewed and approved by AQREC		
	Date/Version	Approved
Letter	10 October 2001	JB
Parent Patient Information Sheet	Attached to above letter	JB
Participant Patient Information Sheet	Attached to above letter	JB
Consent Forms	Attached to above letter	JB

Terms of Reference, Standard Operating Procedures and a list of members of the Ethics Committee are available from the Research & Development office on request.

INDEMNITY

The purpose of an indemnity arrangement for a researcher is to provide legal protection in the event of a researcher led unforeseen adverse circumstance, however minimal the risk, arising during the course of a research project. The indemnity applies to the Senior Investigator in the project and automatically covers any other generally more junior colleagues associated with the project. There are various types of indemnity dependent on the circumstances of the researcher and the nature of the research project. Staff employed in the NHS Trust Hospitals should ensure that they are properly protected by the appropriate indemnity approved by the Trust Chief Executive or Medical Director.

ICH GCP Compliance

The Oxfordshire Research Ethics Committees are compliant with the International Committee on Harmonisation/Good Clinical Practice (ICH_GCP) Guidelines for the Conduct of Trials involving participation of human subjects as they relate to the responsibilities, composition, function, operations and records of an Independent Ethics Committee/Independent Review Board. To this end it undertakes to adhere as far as is consistent with its Constitution, to the relevant clauses of the ICH Harmonised Tripartite Guideline for Good Clinical Practice, adopted by the Commission of the European Union on 17 January 1997.